Original

Children's Hospital @ Erlanger & Erlanger East Hospital

CN1601-002

CERTIFICATE OF NEED APPLICATION

Chattanooga-Hamilton County Hospital Authority

D / B / A

Children's Hospital @ Erlanger

And

Erlanger East Hospital

Application To Modernize The Certificate Of Need
Originally Issued In 2004 (No. CN0405-047AE)
By Initiating A Level III Neonatal Intensive Care Unit,
Reclassifying Medical / Surgical Beds To Neonatal
And Transferring Medical / Surgical Beds

ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

Section A

APPLICANT PROFILE

Section A: APPLICANT PROFILE

Please enter all Section A responses on this form. All questions must be answered. If an item does not apply, please indicate "N/A". ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable item Number on the attachement.***

1. Name of Facility, Agency, or Institution.

Chattanooga-Hamilton County Hospital Authority
D / B / A
Erlanger East Hospital
1755 Gunbarrel Road
Hamilton County
Chattanooga, TN 37416

2. Contact Person Available For Responses To Questions.

Joseph M. Winick, Sr. Vice President
Planning & Business Development
Erlanger Health System
975 East 3rd Street
Chattanooga, TN 37403
(423) 778-8088
(423) 778-7525 -- FAX
Joseph.Winick@erlanger.org -- E-Mail

3. Owner of the Facility, Agency, or Institution.

Chattanooga - Hamilton County Hospital Authority
D / B / A
Erlanger Health System
975 East 3rd Street
Hamilton County
Chattanooga, TN 37403
(423) 778-7000

4. Type of Ownership or Control.

A. Sole Proprietorship _____
B. Partnership _____
C. Limited Partnership _____
D. Corporation (For Profit) _____

E.	Corporation (Not-for-Profit)	
F.	Governmental (State of TN or Political Subdivision)	X
G.	Joint Venture	
H.	Limited Liability Company	
I.	Other (Specify)	

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

-- A copy of the enabling legislation along with a copy of the certification by the Tennessee Secretary of State is attached at the end of this Application.

-- Please note that *Erlanger Health System* is a single legal entity and *Erlanger East Hospital* is an administrative unit of *Erlanger Health System*.

5. Name of Management / Operating Entity (if applicable).

*** Not Applicable. ***

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

6. Legal Interest in the Site of the Institution

(*Check One*)

A.	Ownership	X
B.	Option to Purchase	
C.	Lease of _____ Years	
D.	Option to Lease	
E.	Other (Specify)	

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

7. Type of Institution

(*Check as appropriate – more than one response may apply*)

A.	Hospital (Specify) General Medical / Surgical	X
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty	
C.	ASTC, Single Specialty	
D.	Home Health Agency	
E.	Hospice	
F.	Mental Health Hospital	
G.	Mental Health Residential Treatment Facility	
H.	Mental Health Institutional Habilitation Facility (ICF/MR)	
I.	Nursing Home	
J.	Outpatient Diagnostic Center	
K.	Recuperation Center	
L.	Rehabilitation Facility	
M.	Residential Hospice	
N.	Non-Residential Methadone Facility	
O.	Birthing Center	
P.	Other Outpatient Facility (Specify) _____	
Q.	Other (Specify) _____	

8. Purpose of Review

(Circle Letter(s) as appropriate - more than one response may apply)

A.	New Institution	
B.	Replacement/Existing Facility	
C.	Modification/Existing Facility	
D.	Initiation of Health Care Service As Defined In TCA § 68-11-1607(4) (Specify) *Neonatal Intensive Care*	X
E.	Discontinuance of OB Services	
F.	Acquisition of Equipment	
G.	Change in Beds	X
	[*Please note the type of change by underlining the appropriate response:* Increase, Decrease, Designation, Distribution, Conversion, Relocation]	
H.	Change of Location	
I.	Other (Specify) _____	

9. **Bed Complement Data**

Please indicate current and proposed distribution and certification of facility beds.

		Licensed Beds	*(*) CON Beds*	*Staffed Beds*	*Beds Proposed*	*TOTAL Beds at Completion*
A.	Medical	12	44	12	58	58
B.	Surgical	6	22	6	30	30
C.	Long-Term Care Hospital					
D.	Obstetrical	25		25	25	25
E.	ICU / CCU		4			
F.	Neonatal				10	10
G.	Pediatric					
H.	Adult Psychiatric					
I.	Geriatric Psychiatric					
J.	Child / Adolescent Psychiatric					
K.	Rehabilitation					
L.	Nursing Facility (Non – Medicaid Certified)					
M.	Nursing Facility Level 1 (Medicaid only)					
N.	Nursing Facility Level 2 (Medicare only)					
O.	Nursing Facility Level 2 (dually certified Medicaid / Medicare)					
P.	ICF / MR					
Q.	Adult Chemical Dependency					
R.	Child and Adolescent Chemical Dependency					
S.	Swing Beds					
T.	Mental Health Residential Treatment					
U.	Residential Hospice					
	TOTAL	43	70	43	123	123

(*) CON Beds approved but not yet in service.

Notes

(1) *Erlanger East Hospital* holds a CON for the transfer of up to 79 beds from *Erlanger Medical Center* (no. CN0405-047AE). Nine (9) beds have already been implemented in this process.

(2) *Erlanger East Hospital* also received a CON to transfer six (6) beds from *Erlanger Medical Center* (no. CN0407-067A) for it's Level II *Special Care Nursery*.

(3) *Erlanger East Hospital* operates as a satellite facility of *Erlanger Medical Center* under the Tennessee Dept. of Health - License No. 000140.

(4) *Erlanger East Hospital* was approved in 2004 for a four (4) bed ICU. However, due to adoption of updated "blue tooth" technology that will be utilized, the original

ICU beds have been re-allocated to general acute medical / surgical beds. This technology allows any medical / surgical bed to function as a critical care bed.

10. **Medicare Provider Number** 044-0104

Certification Type General Medical/Surgical

11. **Medicaid Provider Number** 044-0104 (** See note.)

Certification Type General Medical/Surgical

** Please note that the same provider number for Medicare has been shown for Medicaid as well. This is because the individual TennCare MCO's each assign their own particular provider ID numbers. *Erlanger East Hospital* is licensed, and operates as, a satellite facility of *Erlanger Medical Center*.

12. **If this is a new facility, will certification be sought for Medicare and / or Medicaid ?**

Yes _____ No _____

** *Not Applicable - Erlanger East Hospital* currently participates in both the Medicare and TennCare/Medicaid programs as a satellite facility of *Erlanger Medical Center*.

13. ***Identify all TennCare Managed Care Organizations / Behavioral Health Organizations (MCO's/BHO's) operating in the proposed service area.*** **Will this project involve the treatment of TennCare participants ?** *Yes* **If the response to this item is yes, please identify all MCO's/BHO's with which the applicant has constracted *or plans to contract*.**

Discuss any out-of-network relationships in place with MCO's/BHO's in the area.

Response

With the initiation of the *Health Care Exchanges* under the *Affordable Care Act* on January 1, 2014; *Blue Cross Network E* enrolled over 10,000 uninsured people; *Erlanger* is the exclusive provider in this network. Further, an additional 7,000 people were enrolled in *Blue Network S*, where *Erlanger* is one of two providers in this network. *Erlanger* is the low cost and safety net provider in the regional service area and participates in narrow networks to facilitate needed care for those who would otherwise not access to needed healthcare services. Erlanger is also the contract navigation agency for Southeast Tennessee for enrollment of the uninsured using the health insurance exchange.

Erlanger currently has contracts with the following entities.

A. TennCare Managed Care Organizations

-- BlueCare
-- TennCare *Select*
-- AmeriGroup Community Care
-- United Healthcare Community Plan

B. Georgia Medicaid Managed Care Organizations

-- AmeriGroup Community Care
-- Peach State Health Plan
-- WellCare Of Georgia

C. Commercial Managed Care Organizations

-- Blue Cross / Blue Shield of Tennessee
  - Blue Network P
  - Blue Network S
  - Blue Network E
  - Blue CoverTN
  - Cover Kids
  - AccessTN
  - Blue Advantage
-- Blue Cross of Georgia (HMO & Indemnity)
-- Baptist Health Plan
-- CIGNA Healthcare of Tennessee, Inc. (includes LocalPlus)
-- CIGNA Lifesource (Transplant Network)
-- UNITED Healthcare of Tennessee, Inc. (Commercial & Medicare Advantage)
-- Aetna Health

-- Health Value Management D/B/A Choice Care Network (Commercial & Medicare Advantage)
-- HUMANA (Choicecare Network, HMO, PPO, POS & Medicare Advantage)
-- HUMANA Military
-- Cigna-HealthSpring (Commercial & Medicare Advantage)
-- WellCare Medicare
-- Olympus Managed Health Care, Inc.
-- TriWest (VAPC3)

D. Alliances

-- Health One Alliance

E. Networks

-- Multi-Plan (includes Beech Street & PHCS)
-- MCS Patient Centered Healthcare
-- National Provider Network
-- NovaNet (group health)
-- USA Managed Care Corp.
-- MedCost
-- Alliant Health Plan
-- Crescent Preferred Provider Organization
-- Evolutions Healthcare System
-- Prime Health Resources
-- Three Rivers Provider Network
-- Galaxy Health Network
-- First Health Network
-- Integrated Health Plan
-- Logicomp Business Solutions, Inc.
-- HealthSCOPE Benefits, Inc.
-- HealthCHOICE (Oklahoma State & Education Employees Group Insurance Board)

F. Other

-- Alexian Brothers Community Services

Section B

PROJECT DESCRIPTION

Section B: PROJECT DESCRIPTION

Please answer all questions on 8 ½" x 11" white paper, clearly typed and spaced, identified correctly and in the correct sequence. In answering, please type the question and the response. All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer. If a particular question does not apply to your project, indicate "Not Applicable (NA)" after that question.

I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

Response

In 2004, *Erlanger East Hospital* applied for and received approval for a certificate of need (No. CN0405-047AE) for the relocation of 79 additional beds from *Erlanger Medical Center* and the expansion of services to include a full service Emergency Dept. and Cardiac Catheterization Lab for diagnostic procedures. The project has been implemented in phases with several extensions granted for this CON in the intervening 11 years since initial approval. Given the time span since original approval, *Erlanger East Hospital* has a need, and seeks approval, to modernize its facility plan for this phase of the expansion project.

A CON application was submitted in December, 2014, for *Erlanger East Hospital* seeking approval to initiate a satellite radiation therapy service along with the relocation of a Linear Accelerator from *Erlanger Medical Center* (No. CN1412-048); this CON application was approved on March 25, 2015. A CON application was also submitted in February, 2015, to upgrade the Cardiac Catheterization Laboratory originally approved in 2004 from a diagnostic catheterization laboratory to an interventional / therapeutic laboratory (No. CN1502-005); this application was approved on May 27, 2016.

Now *Erlanger East Hospital* seeks approval to initiate and operate a ten (10) bed Level III NICU. *Erlanger East Hospital* is licensed, and operates as, a satellite facility of *Erlanger Medical Center;* it's beds are included in the *Erlanger Medical Center* license. The ten (10) additional Level III NICU beds at *Erlanger East Hospital* will be transferred from *Erlanger Medical Center* and converted to NICU beds, though the total number of licensed beds at *Erlanger* will remain the same at 788. *Erlanger East Hospital* will have 123 beds licensed on completion of the Level III NICU. The existing Level II unit for "sick" newborns (CON No. CN0407-067A) will continue to operate at *Erlanger East Hospital* for those newborn patients not requiring Level III neonatal care.

The Level III NICU at *Erlanger East Hospital* will be managed by *Children's Hospital @ Erlanger. Children's Hospital @ Erlanger* currently operates a 64 bed Level III NICU, and is being reclassified as a Level IV NICU, as it currently meets those standards as detailed in the *Tennessee Perinatal Guidelines. Children's Hospital @ Erlanger* is in process of finalizing plans to replace and expand its hospital in phases which will include further expansion of the NICU. *Children's Hospital @ Erlanger* is the State designated *Regional Perinatal Center* for southeast Tennessee. The hospital provides a complete and comprehensive range of neonatal services to newborn patients who originate from a large geographic area requiring advanced medical care.

Under the management of *Children's Hospital @ Erlanger,* the Level III NICU at *Erlanger East Hospital* will be prepared to provide state of the art NICU services. Clinical staff from *Children's Hospital @ Erlanger* will provide educational programming along with other support and resources, as needed. As an established *Regional Perinatal Center, Children's Hospital @ Erlanger* has the expertise to manage the development and implementation of an efficient and effective Level III NICU. Erlanger's "system of care" is differentiated because core competencies are shared within and between, all of the facilities that comprise *Erlanger Health System,* including a major academic medical center and children's hospital.

This "system of care" allows *Erlanger Health System* to provide complementary services and programs at each campus … a patient in need can gain access to the most advanced

levels of patient care wherever they are located. In addition to programmatic linkage, the expertise and core competencies are linked. Erlanger satellite hospitals are not stand alone, greenfield hospital's that operate independently. They capitalize on the clinical expertise and resources of a major academic medical center and children's hospital which together comprise the foundation of the 7th largest public health system in the United States. Five (5) *Erlanger* hospitals, each on different campuses, actually operate as one.

The Level III NICU at *Erlanger East Hospital* is classified as such, by the *Tennessee Perinatal Guidelines*, 7th Edition, adopted in April, 2014. The Level II neonatal unit at *Erlanger East Hospital* will be increased from six (6) beds to twelve (12) beds as part of the expansion project authorized by the CON approved in 2004. The Level IV unit at *Children's Hospital @ Erlanger* will expand by nine (9) beds, from 64 to 73, using available beds from Erlanger Medical Center. This project is an internal renovation not subject to CON review as no new services or beds will be added and the capital cost is below the $ 5 million threshold. Neonatal services at *Erlanger Health System* are a "*core competency*" and both the Level II and Level III units at *Erlanger East Hospital* will be closely coordinated with the Level IV unit at *Children's Hospital @ Erlanger*. Significant synergy will be created for the Neonatal service line within and across *Erlanger Health System*.

Proposed Services & Equipment

Erlanger East Hospital seeks to modernize the original CON approved in 2004 by initiating a Level III NICU. Ten (10) medical/surgical beds will be transferred from Erlanger Medical Center to *Erlanger East Hospital* and will be converted to NICU beds.

Ownership Structure

The *Chattanooga-Hamilton County Hospital Authority* is a governmental unit of the *State of Tennessee*, created by a private act of the *Tennessee General Assembly* in 1976. The hospital authority does business under the trade names of *Erlanger Health System*, *Erlanger Medical Center*, *Children's Hospital @ Erlanger* and *Erlanger East Hospital*, among others. As a governmental unit, there are no "owners", per se,

other than the people and general public of the *State of Tennessee*.

Service Area

The service area for this project is defined as Hamilton County, Tennessee, and counties that surround Hamilton County in Tennessee, Georgia, Alabama and North Carolina. This service area comprises a total of 30 counties in its 4 state geography. A complete listing of the service area by county is attached to this CON application.

Need

The need for the Level III NICU on the campus of *Erlanger East Hospital* is brought about by, 1.) the institutional need associated with increased NICU utilization at *Children's Hospital @ Erlanger*, 2.) a quantifiable need when evaluating the CON standard for NICU services in the service area, and 3.) implementation of a transitional neonatal program that allows newborns to be placed in the most appropriate setting … whether with the mother, in a Level II nursery or a Level III NICU depending on clinical need.

Existing Resources

Within the service area, there are a total of 90 NICU beds that can serve Level III patients; they are at *Children's Hospital @ Erlanger* (64 beds), Chattanooga, TN; *Parkridge East Hospital* (22 beds), East Ridge, TN; and *Hamilton Medical Center* (4 beds), Dalton, GA. There are a total of 20 NICU beds that can serve Level II patients; they are at *Athens Regional Medical Center* (11 beds), Athens, Tennessee; *Skyridge Medical Center* (3 beds), Cleveland, Tennessee; and *Erlanger East Hospital* (6 beds), Chattanooga, Tennessee. This is a total of 110 neonatal beds in the defined service area.

Project Cost

The project cost is estimated to be $ 7,021,555.

Funding

The funding for this project will be provided from operations of *Erlanger Health System*. A letter from the CFO is attached to this CON application.

Financial Feasibility

The *Projected Data Chart* shows that this project is financially viable in both years 1 and 2.

Staffing

Staffing for the Level III NICU will be 14.4 RN's and 4.4 unit clerks.

II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.

A. Describe the construction, modification and / or renovation to the facility (exclusive of major medical equipment covered by T.C.A. section 68-11-1601 *et seq.*) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of $ 5 million) and other facility projects (construction cost in excess of $ 2 million) should complete the Square Footage And Cost Per Square Foot Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Part B.-E. Please also discuss and justify the cost per square foot for this project.

If the project involves none of the above describe the development of the proposal.

Response

The Level III NICU at *Erlanger East Hospital* will be new construction; the space to be added is 8,805 square feet.

B. Identify the number of beds increased, decreased, converted, relocated, designated, and/or distributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.

Response

Applicant seeks to transfer ten (10) medical/surgical acute care beds from *Erlanger Medical Center* and to convert these beds to NICU Level III beds.

The need for the Level III NICU on the campus of *Erlanger East Hospital* is brought about by, 1.) the institutional need associated with increased NICU utilization at *Children's Hospital @ Erlanger*, 2.) a quantifiable need when evaluating the CON standard for NICU services in the service area, and 3.) implementation of a transitional neonatal program that allows newborns to be placed in the most appropriate setting … whether with the mother, in a Level II nursery or a Level III NICU depending on clinical need.

Children's Hospital @ Erlanger in conjunction with *Erlanger East Hospital* seeks approval to initiate a Level III, ten (10) bed neonatal intensive care unit ("NICU"). The Level III NICU is classified as such by the Tennessee Perinatal Guidelines, 7th Edition, adopted in April, 2014. This will be accomplished by transferring ten (10) general medical / surgical acute care beds from *Erlanger Medical Center* to *Erlanger East Hospital* and conversion of these beds to NICU beds. The Level II unit at *Erlanger East Hospital* will be increased from six (6) beds to twelve (12) beds as part of the expansion project authorized by the CON approved in 2004. The Neonatal service line at *Erlanger Health System* is a "*core competency*" and both the Level II and Level III units at *Erlanger East Hospital* will be closely coordinated with the Level IV unit at *Children's Hospital @ Erlanger*. Significant synergy will be created for the Neonatal service line within *Erlanger Health System*.

The *Square Footage & Cost Per Square Foot Chart* is attached to this CON application.

C. As the applicant, describe your need to provide the following healthcare services (if applicable to this application):

1.	Adult Psychiatric Services	N/A
2.	Alcohol and Drug Treatment for Adolescents (exceeding 28 days)	N/A
3.	Birthing Center	N/A
4.	Burn Units	N/A
5.	Cardiac Catheterization Services	N/A
6.	Child and Adolescent Psychiatric Services	N/A
7.	Extracorporeal Lithotripsy	N/A
8.	Home Health Services	N/A
9.	Hospice Services	N/A
10.	Residential Hospice	N/A
11.	ICF/MR Services	N/A
12.	Long-Term Care Services	N/A
13.	Magnetic Resonance Imaging (MRI)	N/A
14.	Mental Health Residential Treatment	N/A
15.	Neonatal Intensive Care Unit	*** See Below.*
16.	Non-Residential Methadone Treatment Centers	N/A
17.	Open Heart Surgery	N/A
18.	Positron Emission Tomography	N/A
19.	Radiation Therapy/Linear Accelerator	N/A
20.	Rehabilitation Services	N/A
21.	Swing Beds	N/A

Response

Applicant seeks to transfer ten (10) medical/surgical acute care beds from *Erlanger Medical Center* and to convert these beds to NICU Level III beds.

The need for the Level III NICU on the campus of *Erlanger East Hospital* is brought about by, 1.) the institutional need associated with increased NICU utilization at *Children's Hospital @ Erlanger*, 2.) a quantifiable need when evaluating the CON standard for NICU services in the service area, and 3.) implementation of a transitional neonatal program that allows newborns to be placed in the most appropriate setting … whether with the

mother, in a Level II nursery or a Level III NICU depending on clinical need.

Children's Hospital @ Erlanger in conjunction with *Erlanger East Hospital* seeks approval to initiate a Level III, ten (10) bed neonatal intensive care unit ("NICU"). The Level III NICU is classified as such by the Tennessee Perinatal Guidelines, 7th Edition, adopted in April, 2014. This will be accomplished by transferring ten (10) general medical / surgical acute care beds from *Erlanger Medical Center* to *Erlanger East Hospital* and conversion of these beds to NICU beds. The Level II Special Care Nursery at Erlanger East Hospital will be increased from six (6) beds to twelve (12) beds as part of the expansion project authorized by the CON approved in 2004. The Neonatal service line at *Erlanger Health System* is a "*core competency*" and both the Level II and Level III units at *Erlanger East Hospital* will be closely coordinated with the Level IV unit at *Children's Hospital @ Erlanger*. Significant synergy will be created for the Neonatal service line within *Erlanger Health System*.

D. Describe the need to change location or replace an existing facility.

Response

*** Not applicable.*

E. Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of $ 2.0 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:

1. For fixed site major medical equipment (not replacing existing equipment).

   a. Describe the new equipment, including:

      1. Total Cost (as defined by Agency Rule).
      2. Expected useful life.

3. List of clinical applications to be provided.
4. Documentation of FDA approval.

Response

*** Not applicable.*

b. Provide current and proposed schedules of operations.

Response

The schedule of operation for the Level III NICU service at *Erlanger East Hospital* will be 24 hours per day, 7 days per week, 52 weeks per year.

2. For mobile major medical equipment:

a. List all sites that will be served.
b. Provide current and proposed schedules of operations.
c. Provide the lease or contract cost.
d. Provide the fair market value of the equipment.
e. List the owner for the equipment.

Response

*** Not applicable.*

3. Indicate applicant's legal interest in equipment (i.e.-purchase, lease, etc.). In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

Response

The equipment for the NICU on the campus of *Erlanger East Hospital* will be purchased and owned by *Erlanger Health System*.

III. (A) Attach a copy of the plot plan of the site on an 8 ½" x 11" sheet of white paper which **must include**:

1. Size of site (**in acres**).

   -- The *Erlanger East Hospital* campus is located on approximately 26.8 acres. A copy of the plot plan is attached to this CON application.

2. Location of structure on the site.

   -- Please see the location of the Level III NICU on the *Erlanger East Hospital* campus on the schematic drawing attached to this CON application.

3. Location of the proposed construction.

   -- 1755 Gunbarrel Road
   Chattanooga, TN 37416

4. Names of streets, roads or highways that cross or border the site.

   -- Roads that border the site are *Gunbarrel Road* and *Crane Road*.

Please note that the drawings do not need to be drawn to scale. Plot plans are required for all projects.

(B) 1. Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

Response

Erlanger East Hospital is easily accessible to patients in Chattanooga and Hamilton County as well as the surrounding regional service area; from both primary and secondary roads. Additionally, the hospital can be easily accessed via public transportation. Proximal state and interstate highways provide easy access from Tennessee, Georgia, Alabama and North Carolina.

The distance from *Erlanger East Hospital* to *Hamilton Place Mall* is 8/10 of a mile, as evidenced by the map below. *Hamilton Place Mall*, a regional shopping center in Chattanooga, is the largest mall in the *State of Tennessee*. Public transportation is easily accessible to Gunbarrel Road. Further, Interstate 75 is a major highway and is also within 8/10 of a mile.

IV. Attach a floor plan drawing which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc., on an 8 ½" x 11" sheet of white paper.

NOTE: ***DO NOT SUBMIT BLUEPRINTS***. Simple line drawings should be submitted and need not be drawn to scale.

Response

A copy of the floor plan is attached to this CON application.

V. For a Home Health Agency or Hospice, identify:

A. Existing service area by County.
B. Proposed service area by County.
C. A parent or primary service provider.
D. Existing branches.
E. Proposed branches.

Response

*** Not applicable. ***

Section C

GENERAL CRITERIA FOR CERTIFICATE OF NEED

Section C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with Tennessee Code Annotated § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of health care." The three (3) criteria are further defined in Agency Rule 0720-4-.01. Further standards for guidance are provided in the state health plan (Guidelines For Growth), developed pursuant to Tennessee Code Annotated § 68-11-1625.

The following questions are listed according to the three (3) criteria: (1) Need, (2) Economic Feasibility, and (3) Contribution to the Orderly Development of Healthcare. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on 8 ½" x 11" white paper.* All exhibits and tables must be attached to the end of the application in correct sequence identifying the questions to which they refer. If a question does not apply to your project, indicate "Not Applicable (NA)".

PRINCIPLES OF TENNESSEE STATE HEALTH PLAN

[From 2011 Update, Pages 5-13]

1. *Healthy Lives*: The purpose of the State Health Plan is to improve the health of Tennesseans.

Response

Erlanger East Hospital ("*EEH*") is a satellite facility of *Erlanger Medical Center* ("*EMC*"), the safety net hospital for southeast Tennessee; though the hospital also serves northwest Georgia, northeast Alabama and southwest North Carolina due to it's location and the scope and range of services provided. *Erlanger* is the only health system which low-income people, minorities, and other underserved populations can turn to for treatment. As a safety net hospital system, *Erlanger* continually strives to provide services that are the most medically appropriate, least

intensive, and provided in the most cost-effective health care setting.

As the safety net provider, a large underserved population depends on *Erlanger* to provide needed services. While it is difficult to predict the outcome of health reform initiatives, many Tennesseans previously without health insurance can be expected to elect services which may have otherwise been postponed. Growth in the elderly and general population can be expected to increase demand for services. Surveys of the Chattanooga region have shown that some 70% or more of area physicians and surgeons received their training at *Erlanger* via its affiliation with the UT College of Medicine, which is co-located on the *Erlanger Medical Center* campus. Based on current residency and fellowship programs, it can be expected that this trend will continue with many physicians opting to remain in Tennessee, at *Erlanger*.

The proposed initiation of the Level III NICU service at *Erlanger East Hospital* is consistent with the *State Health Plan* because it seeks to ensure patient access to appropriate facilities for Tennesseans. Initiation of the NICU service at *Erlanger East Hospital* will provide access to available NICU services at *Children's Hospital @ Erlanger*, by reducing occupancy levels there which have been exceeding 100 %. *Erlanger* is the safety net for underserved residents in southeast Tennessee, including the only *Children's Hospital* within 100 miles of Chattanooga, Tennessee. Providing enhanced access for those in need regardless of the patients' ability to pay, has been demonstrated to improve the health status of those served.

The Chattanooga region, particularly Enterprise South Industrial Park, located less than 10 minutes away from *Erlanger East Hospital* has proven attractive to business development due to the relatively low cost of labor, cost of living and absence of personal income tax. Also, Chattanooga has been recognized as one of the tenth lowest cost markets from a health care insurance perspective since the roll out of the *Affordable Care Act* and the insurance exchange marketplace.

Volkswagen is in the process of investing $800 million in its Chattanooga manufacturing plant, adding a second automobile line to its production facility. In doing so, Volkswagen expects to employ an additional 2,000 employees,

with the goal to have the second production line up and running in 2016. *Erlanger* has a primary care site on the Volkswagen campus that serves employees and their families as well as others in the community. Volkswagen also has preferred employer status with *Erlanger*, whereby employees receive a discount when services are provided. With this expansion, parts, paint and other suppliers involved with the manufacturing are also expected to add employees … many with young and growing families. Volkswagen has released an additional 300 acres of property to house as many as twenty additional supply companies, increasing site employment to 7,500.

Plastic Omnium Auto Exteriors, LLC, a tier one supplier for Volkswagen, also recently announced that it will make a $65 million investment in Chattanooga, creating nearly 200 new positions at opening, with a target of 300 positions within three years. The company has purchased 27 acres in the industrial park where VW is located.

NV Michel Van De Wielke, one of the largest manufacturers of textile machines in the world indicated it would relocate to Chattanooga from Dalton, GA, to be closer to marketplace competitors and challenge rivals for market share. The plant will employ 35. Chattanooga is the birthplace of tufting with a long tradition in the flooring industry and many manufacturers are still in the region. The company will also relocate its headquarters from Charlotte, NC, to Chattanooga.

On the health front, area hospitals have also invested in plant improvements and technology. *Memorial Hospital* has just completed a renovation and expansion project of approximately $ 300 million. *Parkridge Health System*, an affiliate of *HCA Healthcare*, acquired another hospital in the region (*Grandview Hospital*) and recently completed relocation/expansion of its psychiatric facility with approximately $ 8 million invested. *Skyridge Medical Center*, in Bradley County is owned by *Community Health System*, consolidated two facilities and invested approximately $ 45 million in upgrades.

A large portion of the employees and families of the companies located in *Enterprise South Industrial Park* will be close to, and served by, *Erlanger East Hospital*.

Investment in the region is expected to continue across all industries for the foreseeable future. The Chattanooga Area Chamber of Commerce is expected to meet its goal of adding more than 15,000 jobs.

2. *Access To Care*: Every citizen should have reasonable access to care.

Response

The proposed initiation of the Level III NICU service at *Erlanger East Hospital* is consistent with the *State Health Plan* because it seeks to ensure patient access to appropriate facilities for Tennesseans. Initiation of the NICU service at *Erlanger East Hospital* will provide access to available NICU services at *Children's Hospital @ Erlanger*, by reducing occupancy levels there which have been exceeding 100 %. *Erlanger* is the safety net for underserved residents in southeast Tennessee, including the only *Children's Hospital* within 100 miles of Chattanooga, Tennessee. Providing enhanced access for those in need regardless of the patients' ability to pay, has been demonstrated to improve the health status of those served.

Erlanger is designated by *TennCare* as the safety net hospital, for underserved residents in southeast Tennessee. *Erlanger's* TennCare / Medicaid utilization and uncompensated care cost for the last three (3) fiscal years are presented below.

	TennCare / Medicaid Utilization %	Uncompensated Care Cost
FY 2013	21.0 %	$ 85.1 M
FY 2014	22.3 %	$ 86.2 M
FY 2015	25.0 %	$ 85.1 M

Notes

(1) TennCare / Medicaid utilization percentages are based on gross I/P charges derived from applicant's internal records.

(2) Uncompensated care cost estimates were derived from applicant's internal records as reported in the notes to the annual audited financial statements.

(3) Erlanger's fiscal year begins on July 1 of each year and ends on June 30 of the following year. For example, FY 2015 began on July 1, 2014, and ended on June 30, 2015.

Under the federal Medicare program, an urban hospital with more than 100 beds needs to serve 15% of low-income patients in order to qualify as a "disproportionate share hospital". *Erlanger* clearly shoulders significantly more than its proportionate share of the care rendered to this patient population. The State Health Plan favors initiatives, like the project proposed herein, which help to foster access to the underserved.

Erlanger Medical Center has the only Level I trauma center, the only life-flight helicopter service, and the only *Children's Hospital* in the region which is designated a Level I trauma center as well as a *Regional Perinatal Center*. *Erlanger* is also the largest provider in its service area of Level III neonatal care and perinatal services. *Erlanger Health System* is committed to maintaining its mission of providing healthcare services to all citizen's regardless of ability to pay. Such services include inpatient care, obstetrics, surgical and emergency care.

Erlanger Health System also operates several other hospitals in Southeast Tennessee, of which *Erlanger East Hospital* is a component facility, as well as a network of more than 45 practice sites and physician offices, as well as *Federally Qualified Health Centers* (hereinafter "FQHC"), so that patients may easily access needed services while also facilitating easy access to the broader healthcare delivery system.

3. ***Economic Efficiencies***: **The State's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies, and the continued development of the state's health care system.**

Response

Erlanger Medical Center is very cost efficient within the context of the overall healthcare delivery system. The inpatient net revenue per admission for local hospitals in Chattanooga, Tennessee, is as follows.

Hospital	Avg. Net Revenue Per I/P Admission
Erlanger Medical Center	$ 11,431
Memorial Hospital	$ 11,924

Parkridge Medical Center	$ 13,565
Erlanger East Hospital	$ 6,019
Memorial Hospital - Hixson	$ 5,671
Parkridge East Hospital	$ 7,709

Notes
(1) Information derived from Tennessee Joint Annual Reports for CY 2014.

The inpatient average total charge per admission for *Obstetric* services at local community hospitals in Chattanooga, Tennessee, is as follows.

Hospital	Avg. Total Charge Per I/P Admission
Erlanger East Hospital	$ 7,957
Parkridge East Hospital	$ 13,732

Notes
(1) Information derived from Tennessee Hospital Association market data for CY 2013.

To evidence this, with the initiation of the *Health Care Exchanges* on January 1, 2014; *Blue Network E* enrolled over 10,000 uninsured and *Erlanger* is the only provider in this network. Further, an additional 7,000 people were enrolled in *Blue Network S* and *Erlanger* is one of only two providers in this network as well. It is anticipated that these additional health networks will generate sufficient volume to keep *Erlanger* cost efficient.

While offering more complex services and capabilities, *Erlanger* has net revenue per inpatient admission lower than other large area hospitals. *Erlanger Medical Center* is economically efficient, while incurring higher costs by offering more complex services including the only Level I trauma center, the only life-flight helicopter service, the only children's hospital, the only Level I trauma center, the only Regional Perinatal Center, and the only Level IV neonatal care in southeast Tennessee.[1]

4. *Quality Of Care*: Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers.

1 Level IV as defined by the Tennessee Perinatal Guidelines as well as the American College of Pediatrics.

Response

Erlanger Medical Center, which is accredited by *The Joint Commission*, participates in periodic submission of quality related data to the *Centers For Medicare & Medicaid Services* through its *Hospital Compare* program. *Erlanger East Hospital* is also accredited by *The Joint Commission*. Further, *EMC* and *EEH* have an internal program of *Medical Quality Improvement Committees* which continually monitor healthcare services to assure patients of the quality of care provided. The quality improvement program includes *Erlanger East Hospital* and will include the level III NICU. Patients served at *Erlanger East Hospital* will have the same high quality care available at *Erlanger Medical Center* and *Children's Hospital @ Erlanger*.

5. ***Health Care Workforce*: The state should support the development, recruitment, and retention of a sufficient and quality health care workforce.**

Response

Erlanger Health System has established strong long term relationships with the region's colleges, universities and clinical programs. *Erlanger* provides clinical sites for medical internships and residencies, as well as rotation programs in nursing, radiology, respiratory care and pharmacy, to name a few. A number of regional universities offer Bachelor and higher degree programs in nursing and physical therapy. Locally, two year degrees are available in many clinical allied health areas with additional programs offering advanced technical training in Radiological Imaging such as Nuclear Medicine and Diagnostic Ultrasonography.

The *University of Tennessee - College of Medicine* is co-located at Erlanger and includes training of senior medical students on clinical rotation as well as graduate medical education for training of residents and advanced fellowships in various medical specialties, including surgical specialties, as outlined below.

Residency Programs

Emergency Medicine
Family Medicine
Internal Medicine

Obstetrics & Gynecology
Orthopedic Surgery
Pediatrics
Plastic Surgery
Surgery
Urology
Transitional Year

Fellowship Programs
Orthopedic Trauma Surgery
Surgical Critical Care
Vascular Surgery
Colon & Rectal Surgery
Emergency Medicine
Neuro-Interventional Surgery
Ultrasound
Cardiovascular Disease
Gastroenterology (under development)
Radiology (under development)
Neurology (under development)

Erlanger Health System also participates with numerous schools that provide advanced training in the areas of nursing and allied health.

[End Of Responses To Principles Of Tennessee State Health Plan – 2011 Update, pages 5 – 13]

NEONATAL NURSERY SERVICES

[Standards & Criteria Effective – 2000, p. 18]

1. The total number of neonatal intensive care and intermediate care beds should not exceed eight beds per thousand live births per year in a defined neonatal service area.

Response

The service area for this project is defined as Hamilton County, Tennessee, and counties that surround Hamilton County in Tennessee, Georgia, Alabama and North Carolina. This service area comprises a total

of 30 counties in its 4 state geography. A complete listing of the service area by county is attached to this CON application.

The need for the Level III NICU on the campus of *Erlanger East Hospital* is brought about by, 1.) the institutional need associated with increased NICU utilization at *Children's Hospital @ Erlanger*, 2.) a quantifiable need when evaluating the CON standard for NICU services in the service area, and 3.) implementation of a transitional neonatal program that allows newborns to be placed in the most appropriate setting … whether with the mother, in a Level II nursery or a Level III NICU depending on clinical need.

Within the service area, there are a total of 90 NICU beds that can serve Level III patients; they are at *Children's Hospital @ Erlanger* (64 beds), Chattanooga, TN; *Parkridge East Hospital* (22 beds), East Ridge, TN; and *Hamilton Medical Center* (4 beds), Dalton, GA. There are a total of 20 NICU beds that can serve Level II patients; they are at *Athens Regional Medical Center* (11 beds), Athens, Tennessee; *Skyridge Medical Center* (3 beds), Cleveland, Tennessee; and *Erlanger East Hospital* (6 beds), Chattanooga, Tennessee. This is a total of 110 neonatal beds in the defined service area.

Applicant can demonstrate that the NICU services available at *Erlanger East Hospital* and *Children's Hospital @ Erlanger* are not "interchangeable" with NICU services available at other hospitals in the service area. By this, it is meant that Erlanger's NICU service is where the other NICU providers send high acuity newborn's which they cannot treat due to skill level limitations, and also due to the complete range of pediatric specialist's at *Children's Hospital @ Erlanger*.

The institutional need is derived, in part, from utilization analysis of the Level III NICU at *Children's Hospital @ Erlanger*, following is a summary for the last three (3) years.

Calendar Year	Average Daily Census	Occupancy
2012	44.0	78.6 %
2013	43.2	77.1 %
2014	52.8	94.3 %

Following is a summary of the Level III NICU utilization at Children's Hospital @ Erlanger for 2015, by month.

Month Of 2015	Average Daily Census	% Occupancy
January	54.4	97.7 %
February	53.8	96.1 %
March	58.4	104.3 %
April	60.5	108.0 %
May	62.2	111.1 %
June	62.0	110.7 %
July	56.6	101.1 %
August	57.7	103.0 %
September	60.2	107.5 %
October	53.7	95.9 %
November	66.4	118.6 %
December	70.3	125.5 %

Notes
(1) Occupancy for the NICU is calculated based on 56 NICU beds with permanent monitoring equipment.

In the NICU at *Children's Hospital @ Erlanger* the "effective capacity" of this unit is 56 beds, although 64 beds are licensed. This is the number of beds which have a "permanent monitor". However, due to the increased need for the NICU service, eight (8) additional beds have been set up with mobile monitoring equipment due to space constraints within the NICU unit.

As can be seen, utilization for the Level III NICU at *Children's Hospital @ Erlanger* frequently exceeds the 56 bed "capacity". The size and space limitations will be addressed with the replacement of *Children's Hospital @ Erlanger*, which is currently being planned. The Level III NICU at Erlanger East Hospital will allow clinically appropriate newborns to be served by that unit, which is also to be managed by *Children's Hospital @ Erlanger*.

The service area has a total number of projected live births in 2019 of 15,670. The number of NICU beds required is 126. This is derived by multiplying the number of NICU beds required per thousand live births times the number of thousand live births (8 beds x 15.7 = 126). The number of needed beds is determined by subtracting the number of beds required from the number of beds currently available. Therefore, the number of NICU beds needed is 16 (126 - 110 = 16). This CON application seeks to add ten (10) Level III NICU beds at *Erlanger East Hospital*. Six (6) beds will

be added to the existing Level II unit at *Erlanger East Hospital*.

2. The need shall be based upon the current year's population projected four years forward.

Response

The population used for determination of the projected bed need in criterion 1 above, was derived by obtaining the estimated population for Tennessee counties from the Tennessee Dept. of Health and the population for all other non-Tennessee counties was obtained from Nielsen Claritas. The projected need of 126 NICU beds is based on the projected population in 2019, as required by this criterion of the population projected four years forward.

3. A single neonatal special care unit shall contain a minimum of 15 beds. This is considered to be the minimum necessary to support economical operation of this service. An adjustment in the number of beds may be justified due to geographic remoteness.

Response

Erlanger East Hospital is licensed, and currently operates as, a satellite facility of *Erlanger Medical Center*. *Children's Hospital @ Erlanger* already has a licensed NICU of 64 beds and the instant application simply seeks to add additional beds. As such, this criterion is met for a minimum number of fifteen (15) NICU beds. The Neonatal service line at *Erlanger Health System* is a "*core competency*" and both the Level II and Level III units at *@ Erlanger East Hospital* will be closely coordinated with the Level IV unit at *Children's Hospital @ Erlanger*. Significant synergy will be created for the Neonatal service line within *Erlanger Health System*.

Erlanger East Hospital currently has a six (6) bed Level II unit, so with the addition of six (6) more beds to this unit through the expansion CON approved in 2004, it will be a 12 bed Level II unit. Further, with the ten (10) bed Level III NICU which is the subject of this CON application, *Erlanger East Hospital* will have a total of twenty-two (22) neonatal beds.

The neonatal bed complement on the campus of *Erlanger East Hospital* will be part of a "system of care" for neonatal infants within the only health system in the regional service area which can provide such a significant continuity of care for this vulnerable population. The clinical skills of staff members will be transferable, and staff will actually be rotated, between the Level II and Level III units at *Erlanger East Hospital* as well as the Level IV NICU at *Children's Hospital @ Erlanger*. *Children's Hospital @ Erlanger* will manage the neonatal service at *Erlanger East Hospital*.

4. The applicant shall designate a specific area which is compatible with Department of Health guidelines to this service.

Response

The service area for this project is defined as Hamilton County, Tennessee, and counties that surround Hamilton County in Tennessee, Georgia, Alabama and North Carolina. This service area comprises a total of 30 counties in its 4 state geography. A complete listing of the service area by county is attached to this CON application.

Within the service area, there are a total of 90 NICU beds that can serve Level III patients; they are at *Children's Hospital @ Erlanger* (64 beds), Chattanooga, TN; *Parkridge East Hospital* (22 beds), East Ridge, TN; and *Hamilton Medical Center* (4 beds), Dalton, GA. There are a total of 20 NICU beds that can serve Level II patients; they are at *Athens Regional Medical Center* (11 beds), Athens, Tennessee; *Skyridge Medical Center* (3 beds), Cleveland, Tennessee; and *Erlanger East Hospital* (6 beds), Chattanooga, Tennessee. This is a total of 110 neonatal beds in the defined service area.

Applicant can demonstrate that the NICU services available at *Erlanger East Hospital* and *Children's Hospital @ Erlanger* are not "interchangeable" with NICU services available at other hospitals in the service area. By this, it is meant that Erlanger's NICU service is where the other NICU providers send high acuity newborn's which they cannot treat due to skill level limitations, and also due to the

complete range of pediatric specialist's at *Children's Hospital @ Erlanger*.

The service area has a total number of projected live births in 2019 of 15,670. The number of NICU beds required is 126. This is derived by multiplying the number of NICU beds required per thousand live births times the number of thousand live births (8 beds x 15.7 = 126). The number of needed beds is determined by subtracting the number of beds required from the number of beds currently available. Therefore, the number of NICU beds needed is 16 (126 - 110 = 16). This CON application seeks to add ten (10) Level III NICU beds at *Erlanger East Hospital*. Six (6) beds will be added to the existing Level II unit at *Erlanger East Hospital*.

5. The applicant should demonstrate the ability to comply with the standards developed in the Tennessee Perinatal Care System Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities.

Response

The standards developed in the Tennessee Perinatal Care System Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities are addressed immediately following these neonatal standards and criteria.

6. The target population shall have access to the proposed service in terms of payment for services, transportation, parking, geographical barriers, and access for the handicapped.

Response

Erlanger East Hospital will serve all patients, regardless of ability to pay. Further, any patient who is in need of the specialized NICU service will be served regardless of ability to pay. Additional parking is being added on the *Erlanger East Hospital* campus in conjunction with the final phase of the expansion project. Further, all services are handicap accessible.

Erlanger East Hospital is easily accessible to patients in Chattanooga and Hamilton County as well as the

surrounding service area; from both primary and secondary roads. Additionally, the hospital can be easily accessed via public transportation. Proximal state and interstate highways provide easy access from Tennessee, Georgia, Alabama and North Carolina.

7. The Department of Health will consult the Perinatal Advisory Committee regarding applications.

Response

Applicants acknowledge that *The Perinatal Advisory Committee* will be consulted by the *Tennessee Dept. of Health* concerning applications for NICU services.

[End Of Responses To Standard & Criteria For Neonatal Nursery Services, 2000, page 18]

TENNESSEE PERINATAL CARE SYSTEM

Guidelines For Regionalization, Hospital Care Levels, Staffing And Facilities

[Perinatal Standards Effective April 24, 2014, Level 3 - Seventh Edition, p. 35 - 38]

>>>>> A. Educational Services <<<<<

Educational services should include the following:

1. Parent Education: Ongoing perinatal education programs for parents.

Response

There will be a full time perinatal educator located at *Erlanger East Hospital* to provide ongoing perinatal education programs, along with support as needed from the Level IV NICU at the *Regional Perinatal Center* located at *Children's Hospital @ Erlanger*.

2. **Nurses Education: Level III units are required to provide ongoing educational programs for their nurses that conform to the latest edition of Tennessee Perinatal Care System Educational Objectives for Nurses, Level III, for neonatal nurses, published by the Tennessee Department of Health. Outreach educational activities are not included.**

Response

There will be a full time perinatal educator located at *Erlanger East Hospital* to provide ongoing perinatal education programs. For purposes of this criterion, the full time educator will work in conjunction with the perinatal education staff at *Children's Hospital @ Erlanger* to provide ongoing educational programs for nursing staff.

3. **Physicians Education: Level III units are required to provide ongoing educational programs for physicians practicing in that institution. Outreach educational activities are not required.**

Response

There will be a full time perinatal educator located at *Erlanger East Hospital* to provide ongoing perinatal education programs. For purposes of this criterion, the full time educator will work in conjunction with the perinatal education staff at *Children's Hospital @ Erlanger* as well as the Medical Affairs Dept. at *Erlanger Medical Center* to provide ongoing educational programs for physicians.

4. **All neonatal care providers should maintain both current NRP and S.T.A.B.L.E. provider status. The S.T.A.B.L.E. Cardiac Module is also recommended.**

Response

The NICU at *Erlanger East Hospital* will maintain current NRP and S.T.A.B.L.E. provider status.

>>>>> B. Neonatal Care <<<<<

1. **Resuscitation: Provision must be made for resuscitation of infants immediately after birth. Resuscitation capabilities should include assisted ventilation with blended oxygen administered by bag or T-piece resuscitator with mask or endotracheal tube, chest compression, and appropriate intravascular therapy. Refer to the most recent edition of the American heart Association and American Academy of Pediatrics Neonatal Resuscitation Guidelines for a complete list of resuscitation equipment and supplies.**

Response

The Level III NICU at *Erlanger East Hospital* will have the capability to resuscitate infants immediately after birth, if needed.

2. **Tranport from Delivery Room to the Special Care Nursery: Transport to a special care nursery requires a capacity for uninterrupted support. An appropriately equipped pre-warmed transport incubator, with blended oxygen, should be used for this purpose.**

Response

The Level III NICU at *Erlanger East Hospital* will have the capability to transport infants from the delivery room to the special care nursery in an equipped pre-warmed transport incubator with blended oxygen.

3. **Transitional Care: Recurrent observation of the neonate should be performed by personnel who can identify and respond to the early manifestations of neonatal disorders.**

Response

The NICU at *Erlanger East Hospital* will have staff that are trained to identify and respond to early manifestations of neonatal disorders.

4. **Care of Sick Neonates: The care of moderately and severely ill infants entails the following essentials:**

a. Continuous cardiorespiratory monitoring.
b. Serial blood gas determinations and non-invasive blood gas monitoring.
c. Periodic blood pressure determinations (intra-arterial when necessary).
d. Portable diagnostic imaging for bedside interpretation.
e. Availability of electrocardiograms with rapid interpretation.
f. Laboratory Services: Clinical laboratory services must be available to fully support clinical neonatal functions.
g. Fluid and electrolyte management and administration of blood and blood components.
h. Phototherapy and exchange transfusion.
i. Administration of parenteral nutrition through peripheral or central vessels.
j. Provision of appropriate enteral nutrition and lactation support.

Response

The NICU at *Erlanger East Hospital* will have all of the listed services available to infants who may be in need.

5. Mechanical Ventilatory Support: The Level III unit must be qualified to provide mechanical ventilator support. The essential qualifications are as follows:

a. Continuous in-house presence of personnel experienced in airway management, endotracheal intubation, and diagnosis and treatment of air leak syndromes.
b. A staff of nurses (R.N.) and respiratory therapists (R.T.) who are specifically educated in the management of neonatal respiratory disorders.
c. Blood gas determinations and other data essential to treatment must be available 24 hours a day.
d. Level III nurseries should be able to provide a full range of respiratory support, including sustained conventional and/or high frequency ventilation and inhaled nitric oxide.

Response

The NICU at *Erlanger East Hospital* will have all of the listed services available to infants who may be in need.

6. **Diagnostic Imaging: Perform advanced imaging, with interpretation on an urgent basis, including CT, MRI, and echocardiography.**

Response

The NICU at *Erlanger East Hospital* will have all of these imaging services available to infants who may be in need.

7. **Laboratory Services: Clinical laboratory services must available to fully support clinical neonatal functions.**

Response

The NICU at *Erlanger East Hospital* will have all a fully functioning laboratory service available to infants who may be in need.

8. **Blood Bank Services: Blood bank services must be maintained at all times. An appropriately trained technician should be available in-house 24 hours daily. All blood components must be obtainable on an emergency basis, either on the premises or by pre-arrangement with another facility.**

Response

The NICU at *Erlanger East Hospital* will have blood bank services available at all times, to infants who may be in need.

>>>>> C. Consultation And Transfer <<<<<

1. **Neonatal Transport:**

a. **The Level III facility that operates a transport service is required to maintain equipment and a trained team of personnel that must be available at all times for the transport of newborn patients. The Level III facility is responsible for transport of referred infants with its own equipment, or alternatively, with equipment from a commercial source.**

Response

The Level III NICU at *Erlanger East Hospital* will have access to the neonatal transport service based at *Children's Hospital @ Erlanger* and this service will be available immediately upon request.

b. **The Level III facility that operates a transport service should originate a protocol that describes procedures, staffing patterns, and equipment for the transport of referred infants. The protocol should conform to the most recent edition of the Tennessee Perinatal Care System Guidelines On Transportation, published by the Tennessee Department of Health.**

Response

The Level III NICU at *Erlanger East Hospital* will have access to the neonatal transport service based at *Children's Hospital @ Erlanger* and this service will be available immediately upon request.

The protocol conforms to the Tennessee Perinatal System Guidelines On Transportation and is attached to this CON application.

c. **The Level III facility that operates a transport service is required to maintain records of its activities. (See the most recent edition of the Tennessee Perinatal Care System Guidelines on Transportation)**

Response

The Level III NICU at *Erlanger East Hospital* will have access to the neonatal transport service based at *Children's Hospital @ Erlanger* and this service will be available immediately upon request.

The neonatal transport service maintains a record of it's activities in compliance with Tennessee Perinatal System Guidelines On Transportation.

>>>>> D. Maintenance Of Data And <<<<<
>>>>> Assessment Of Quality Measures <<<<<

A systematic ongoing compilation of data should be maintained to reflect the care of sick patients, in addition to the listing of minimal data that is specified for Level I and level II facilities. All Level III programs should participate in a state or national continuous quality improvement initiative that includes ongoing data collection and review for benchmarking and evaluation of outcomes.

Response

For NICU services, *Erlanger Health System* participates in the Vermont Oxford Quality Monitoring service. If this CON application is approved, the NICU located at *Erlanger East Hospital* will also participate in the Vermont Oxford Quality Monitoring service as a member facility of *Erlanger Health System*.

[End Of Responses To Perinatal Standards Effective April 24, 2014, Level 3 - Seventh Edition, p. 35 - 38]

GENERAL QUESTIONS CONCERNING NEED, ECONOMIC FEASIBILITY & CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE

(I.) *NEED*

1. Describe the relationship of this proposal toward the implementation of the State Health Plan, Teneessee's Health: Guidelines For Growth.

(a) Please provide a response to each criterion and standard in Certificate Of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.

Response

This project is consistent with the *Principles Of The Tennessee State Health Plan* as stated in the 2011 update ("Principles"). *Applicant* has addressed each of the *Principles*.

(b) Applications that include a Change of Site for a health care institution, provide a response to General Criterion and Standards (4)(a-c).

Response

** Not applicable. **

2. Describe the relationship of this proposal to the applicant facility's long range development plans, if any.

Response

Erlanger Health System currently holds a CON for expansion of *Erlanger East Hospital* (No. CN0405-047AE); and a CON to modernize and upgrade the surgical facilities at *Erlanger Medical Center* (No. CN1207-034A).

As part of the long range development plan for *Erlanger East Hospital*, the HSDA approved an extension of the CON (CN0405-047AE) on September 24, 2014, for the transfer of up to 70 additional beds from *Erlanger Medical Center*. The expansion of *Erlanger East Hospital* is in process.

Given the time span since original approval, *Erlanger East Hospital* has a need, and seeks approval, to modernize its facility plan for this phase of the expansion project. In a similar fashion, a CON application was approved on

March 23, 2015, for *Erlanger East Hospital* to initiate a satellite radiation therapy service along with the relocation of a Linear Accelerator from *Erlanger Medical Center* (no. CN1412-048). Further, a CON application was submitted in February, 2015, to upgrade the Cardiac Catheterization Laboratory originally approved in 2004 from a diagnostic catheterization laboratory to an interventional / therapeutic laboratory (No. CN1502-005); this application was approved on May 27, 2016.

The goal for *Erlanger Health System* is to provide a comprehensive system of care comprised of unduplicated services while also serving those who are currently under served and/or those who do not have the ability to pay for their services. The Level III NICU *Erlanger East Hospital* is part of our long term plan to make services more accessible.

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. Please submit maps on 8 ½" x 11" sheets of white paper marked only with ink detectable by a standard photocopier (i.e-no highlighters, pencils, etc.).

Response

The service area for this project is defined as Hamilton County, Tennessee, and counties that surround Hamilton County in Tennessee, Georgia, Alabama and North Carolina. This service area comprises a total of 30 counties in its 4 state geography. A complete listing of the service area by county is attached to this CON application.

The need for the Level III NICU on the campus of *Erlanger East Hospital* is brought about by, 1.) the institutional need associated with increased NICU utilization at *Children's Hospital @ Erlanger*, 2.) a quantifiable need when evaluating the CON standard for NICU services in the service area, and 3.) implementation of a transitional neonatal program that allows newborns to be placed in the most appropriate setting … whether with the mother, in a Level II nursery or a Level III NICU depending on clinical need.

Within the service area, there are a total of 90 NICU beds that can serve Level III patients; they are at *Children's Hospital @ Erlanger* (64 beds), Chattanooga, TN; *Parkridge East Hospital* (22 beds), East Ridge, TN; and *Hamilton Medical Center* (4 beds), Dalton, GA. There are a total of 20 NICU beds that can serve Level II patients; they are at *Athens Regional Medical Center* (11 beds), Athens, Tennessee; *Skyridge Medical Center* (3 beds), Cleveland, Tennessee; and *Erlanger East Hospital* (6 beds), Chattanooga, Tennessee. This is a total of 110 neonatal beds in the defined service area.

Applicant can demonstrate that the NICU services available at *Erlanger East Hospital* and *Children's Hospital @ Erlanger* are not "interchangeable" with NICU services available at other hospitals in the service area. By this, it is meant that Erlanger's NICU service is where the other NICU providers send high acuity newborn's which they cannot treat due to skill level limitations, and also due to the complete range of pediatric specialist's at *Children's Hospital @ Erlanger*.

The institutional need is derived, in part, from utilization analysis of the Level IV NICU at *Children's Hospital @ Erlanger*, following is a summary for the last three (3) years.

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Following is a summary of the Level IV NICU utilization at *Children's Hospital @ Erlanger* for 2015, by month.

Month Of 2015	Average Daily Census	% Occupancy
January	54.4	97.7 %
February	53.8	96.1 %
March	58.4	104.3 %
April	60.5	108.0 %
May	62.2	111.1 %
June	62.0	110.7 %
July	56.6	101.1 %
August	57.7	103.0 %
September	60.2	107.5 %
October	53.7	95.9 %
November	66.4	118.6 %

December	70.3	125.5 %

Notes
(1) Occupancy for the NICU is calculated based on 56 NICU beds with permanent monitoring equipment.

In the NICU at *Children's Hospital @ Erlanger* the "effective capacity" of this unit is 56 beds, although 64 beds are licensed. This is the number of beds which have a "permanent monitor". However, due to the increased need for the NICU service, eight (8) additional beds have been set up with mobile monitoring equipment due to space constraints within the NICU unit.

As can be seen, utilization for the Level III NICU at *Children's Hospital @ Erlanger* frequently exceeds the 56 bed "capacity". The size and space limitations will be addressed with the replacement of *Children's Hospital @ Erlanger*, which is currently being planned. The Level III NICU at Erlanger East Hospital will allow clinically appropriate newborns to be served by that unit, which is also to be managed by *Children's Hospital @ Erlanger*.

The service area has a total number of projected live births in 2019 of 15,670. The number of NICU beds required is 126. This is derived by multiplying the number of NICU beds required per thousand live births times the number of thousand live births (8 beds x 15.7 = 126). The number of needed beds is determined by subtracting the number of beds required from the number of beds currently available. Therefore, the number of NICU beds needed is 16 (126 - 110 = 16). This CON application seeks to add ten (10) Level III NICU beds at *Erlanger East Hospital*. Six (6) beds will be added to the existing Level II unit at *Erlanger East Hospital*.

4. A. Describe the demographics of the population to be served by this proposal.

Response

The service area of the applicant is defined above. Estimated live births for the 28 county service area in 2019 of 15,670. The newborn population that are in need of this highly specialized service are truly the most vulnerable patients.

Information pertaining to the neonatal patient group is within the age cohort of those 0-4 years of age. As such, this age cohort decreased from 87,476 to 84,736 between 2010 and 2015, or 3.1%. However, the growth rate between 2015 and 2019 is expected to grow by 515, or 0.6%. This represents an inflection point in the demographics of the service area for the 0-4 age group, and this age cohort likely will continue to experience additional growth.

A summary of other demographic information is also presented which outlines changes in population, *TennCare* enrollment and population below the Federal poverty level for each county within of the service area that is located in Tennessee.

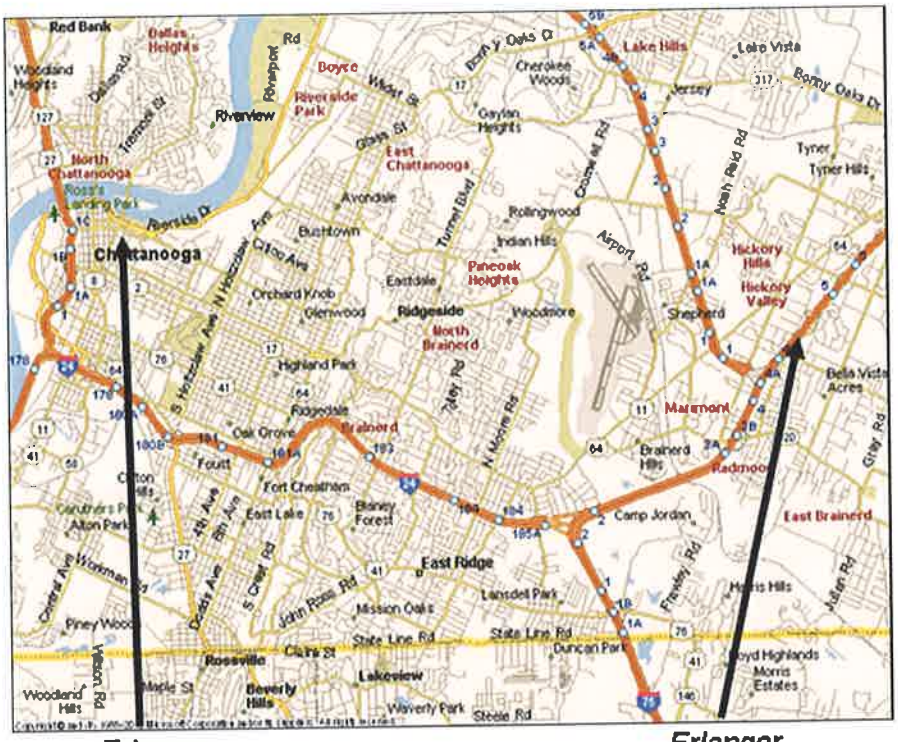
	Hamilton	Bradley	Marion	Grundy	Sequatchie	Bledsoe		
Current Year (2015) - Age 65+	57,974	16,985	5,502	2,693	2,916	2,360		
Projected Year (2019) - Age 65+	64,174	19,036	5,920	2,837	3,372	2,569		
Age 65+ - % Change	10.7%	12.1%	7.6%	5.3%	15.6%	8.9%		
Age 65+ - % Total	16.6%	16.3%	19.2%	20.2%	19.1%	18.7%		
Total Pop. - 2015	349,273	104,364	28,652	13,322	15,246	12,610		
Total Pop. - 2019	354,610	108,511	29,125	13,303	16,270	12,637		
Total Pop. - % Change	1.5%	4.0%	1.7%	-0.1%	6.7%	0.2%		
Median Age	39	38	42	41	41	42		
Median Household Income	$46,702	$41,083	$41,268	$26,814	$36,434	$33,443		
TennCare Enrollees	61,399	20,321	6,636	4,626	3,716	3,082		
TennCare Enrollees As % Of Total Pop.	17.6%	19.5%	23.2%	34.7%	24.4%	24.4%		
Persons Below Poverty Level	59,979	20,664	5,215	3,957	2,653	2,825		
Persons Below Poverty Level As % Of Total Pop.	17.2%	19.8%	18.2%	29.7%	17.4%	22.4%		
	Rhea	Meigs	McMinn	Polk	Franklin	Coffee		
Current Year (2015) - Age 65+	6,217	2,560	10,126	3,341	7,479	7,938		
Projected Year (2019) - Age 65+	6,907	2,869	10,845	3,607	7,402	7,261		
Age 65+ - % Change	11.1%	12.1%	7.1%	8.0%	-1.0%	-8.5%		
Age 65+ - % Total	18.4%	20.8%	18.9%	20.2%	18.1%	14.5%		
Total Pop. - 2015	33,767	12,331	53,476	16,570	41,391	54,817		
Total Pop. - 2019	35,081	12,697	54,457	16,609	42,408	57,619		
Total Pop. - % Change	3.9%	3.0%	1.8%	0.2%	2.5%	5.1%		
Median Age	40	43	42	43	41	40		
Median Household Income	$36,741	$35,150	$39,410	$39,074	$42,904	$37,618		
TennCare Enrollees	8,490	2,907	11,270	3,784	7,166	12,252		
TennCare Enrollees As % Of Total Pop.	25.1%	23.6%	21.1%	22.8%	17.3%	22.4%		
Persons Below Poverty Level	7,631	2,553	9,786	2,867	6,250	11,457		
Persons Below Poverty Level As % Of Total Pop.	22.6%	20.7%	18.3%	17.3%	15.1%	20.9%		
							Service Area	State Of Tennessee
	Warren	Van Buren	White	Monroe				
Current Year (2015) - Age 65+	6,823	1,149	5,132	9,325			148,520	1,012,937
Projected Year (2019) - Age 65+	7,339	1,286	5,423	10,680			161,527	1,134,565
Age 65+ - % Change	7.6%	11.9%	5.7%	14.5%			8.8%	12.0%
Age 65+ - % Total	16.8%	21.1%	18.9%	20.0%			17.4%	15.2%
Total Pop. - 2015	40,662	5,433	27,132	46,563			855,609	6,649,438
Total Pop. - 2019	41,362	5,488	28,275	48,648			877,100	6,894,997
Total Pop. - % Change	1.7%	1.0%	4.2%	4.5%			2.5%	3.7%
Median Age	39	45	42	42				38
Median Household Income	$34,641	$33,547	$34,474	$37,595			$45,482	$44,298
TennCare Enrollees	10,217	1,242	6,574	10,881			174,563	1,331,838
TennCare Enrollees As % Of Total Pop.	25.1%	22.9%	24.2%	23.4%			20.4%	20.0%
Persons Below Poverty Level	8,742	1,222	5,399	9,126			160,326	1,170,301
Persons Below Poverty Level As % Of Total Pop.	21.5%	22.5%	19.9%	19.6%			18.7%	17.6%

B. The special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

Response

As member facilities of *Erlanger Health System*, *Children's Hospital @ Erlanger* and *Erlanger East Hospital* are components of the safety net for southeast Tennessee. Often the only hospital which low-income people, minorities, and other underserved populations can turn to for treatment is *Erlanger*. In order to assure the continued viability of its mission as the safety net provider, *Erlanger Health System* continually strives to provide services that are medically appropriate, least intensive (restrictive), and provided in the most cost-effective health care setting.

The *Erlanger East Hospital* campus is accessible to patients in Chattanooga and Hamilton County from both primary and secondary roads. Additionally, the hospital can be easily accessed via public transportation. Further, proximal state and interstate highways provide easy access from Tennessee, Georgia and Alabama.



Information pertaining to the neonatal patient group is within the age cohort of those 0-4 years of age. As such, this age cohort decreased from 87,476 to 84,736 between 2010 and 2015, or 3.1%. However, the growth rate between 2015 and 2019 is expected to grow by 515, or 0.6%. This represents an inflection point in the demographics of the service area for the 0-4 age group, and this age cohort likely will continue to experience additional growth.

Erlanger has also been responsive to the needs of employees and families of new businesses like VW, Amazon and Wacker Chemical which have generated thousands of new jobs in the area. The proposed project will help ensure that the service area population have access to services and facilities consistent with their needs and evolving industry standards.

5. Describe the existing or certified services, including approved but unimplemented CON's, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its

utlilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.

Response

Utilization data for NICU services within the defined service area located in Tennessee are presented below.

Neonatal Intensive Care Units Utilization

	NICU Level	No. Of Beds	== CY 2011 === Cases	Pt. Days	== CY 2012 === Cases	Pt. Days	== CY 2013 === Cases	Pt. Days	== CY 2014 === Cases	Pt. Days
Children's Hospital @ Erlanger	IV	64	738	17,585	671	16,061	739	15,651	854	17,377
Parkridge East Hospital	III	22	174	2,730	256	3,736	288	4,584	346	4,815
Starr Regional Medical Center	II	11	-	-	-	-	425	1,099	388	668
Skyridge Medical Center	II	3	-	-	48	208	58	205	90	240
Erlanger East Hospital	II	6	-	-	-	-	-	-	210	1,529
		106	912	20,315	975	20,005	1,510	21,539	1,888	24,629
Occupancy										
Children's Hospital @ Erlanger				75.3%		68.8%		67.0%		74.4%
Parkridge East Hospital				34.0%		46.5%		57.1%		60.0%
Starr Regional Medical Center				-		-		27.4%		16.6%
Skyridge Medical Center				-		19.0%		18.7%		21.9%
Erlanger East Hospital				-		-		-		69.8%

NOTES

(1) This information is derived from *Tennessee Joint Annual Reports*.

(2) Occupancy is for *Erlanger Medical Center* NICU is calculated based on the number of beds with "permanent" monitors, not mobile monitoring equipment.

Applicant can demonstrate that the NICU services available at *Erlanger East Hospital* and *Children's Hospital @ Erlanger* are not "interchangeable" with NICU services available at other hospitals in the service area. By this, it is meant that Erlanger's NICU service is where the other NICU providers send high acuity newborn's which they cannot treat due to skill level limitations, and also due to the complete range of pediatric specialist's at *Children's Hospital @ Erlanger*.

Utilization data for the three (3) community hospitals in Chattanooga, Tennessee, is presented below.

Community Hospitals -- Chattanooga, Tennessee
General Utilization Trends

	2012			2013			2014		
	Erlanger East	Memorial Hixson	Parkridge East	Erlanger East	Memorial Hixson	Parkridge East	Erlanger East	Memorial Hixson	Parkridge East
General Acute Care - Admissions	4,909	4,194	5,393	4,803	4,088	5,487	4,379	4,232	6,625
Inpatient Pt. Days - Acute Care	10,382	16,982	19,103	10,278	16,617	20,617	9,276	17,461	23,240
General Acute Care - ALOS	2.11	4.05	3.54	2.14	4.06	3.76	2.12	4.13	3.51
ED Visits	0	30,636	42,033	6,100	25,516	38,136	22,009	30,798	41,422
Total Surgical Patients	8,576	4,056	4,253	8,407	3,923	4,104	8,328	3,911	4,173
OB Deliveries	2,607	0	3,154	2,531	0	3,128	2,508	0	4,164

NOTES
(1) This information is derived from *Tennessee Joint Annual Reports*.

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.

Response

Utilization data for *Erlanger East Hospital* is presented below.

Erlanger East Hospital
General Utilization Trends

					Projected Utilization				
	2012	2013	2014	2015	2016	2017	2018	2019	2020
General Acute Care - Admissions	2,840	2,709	2,640	2,908	2,930	2,952	2,973	2,995	3,017
Inpatient Pt. Days - Acute Care	6,406	6,161	5,690	6,378	6,426	6,473	6,521	6,569	6,616
General Acute Care - ALOS	2.26	2.27	2.16	2.19	2.19	2.19	2.19	2.19	2.19
ED Visits	0	6,100	22,008	26,172	24,748	25,367	26,001	26,651	27,317
Total Surgical Patients	3,182	3,183	3,262	3,527	3,282	3,306	3,331	3,355	3,379
OB Deliveries	2,619	2,553	2,508	2,592	2,619	2,638	2,657	2,677	2,696

NOTES
(1) This information is derived from the internal records of *Erlanger Health System*.
(2) The trends outlined are based on historical trends. Upon completion of the expansion project at *Erlanger East Hospital* (no. CN0407-047), utilization will be higher.

The projected utilization is based upon a use rate average calculation for the four (4) year period of 2012 - 2015. Expected growth could exceed this forecast based on

hospital referral patterns, health reform initiatives and/or advances in clinical care. Further, the expansion project for *Erlanger East Hospital* will result in additional growth when that project is completed.

(II.) ***ECONOMIC FEASIBILITY***

1. **Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.**

   - **All projects should have a project cost of at least $ 3,000 on Line F (minimum CON filing fee). CON filing fee should be calculated from Line D. (See application instructions for filing fee.)**

   - **The cost of any lease should be based on fair market value or the total amount of lease payments over the initial term of the lease, whichever is greater.**

   - **The cost of fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.**

   - **For projects that include new construction, modification, and/or renovation; documentation must be provided from a contractor and/or architect that support the estimated construction costs.**

Response

The *Project Cost Chart* has been completed on the next page.

PROJECT COST CHART

A.	Construction And Equipment Acquired By Purchase.	
1.	Architecural And Engineering Fees	218,244
2.	Legal, Administrative, Consultant Fees (Excluding CON Filing Fees)	85,639
3.	Acquisition Of Site	
4.	Preparation Of Site	
5.	Construction Costs	3,551,783
6.	Contingency Fund	636,890
7.	Fixed Equipment (Not Included In Construction Contract)	
8.	Moveable Equipment (List all equipment over $ 50,000)	2,156,732
9.	Other (Specify) IS, Technical, Signage, etc.	356,503
B.	Acquisition By Gift, Donation, Or Lease.	
1.	Facility (inclusive of building and land)	
2.	Building Only	
3.	Land Only	
4.	Equipment (Specify)	
5.	Other (Specify)	
C.	Financing Costs And Fees.	
1.	Interim Financing	
2.	Underwriting Costs	
3.	Reserve For One Year's Debt Service	
4.	Other (Specify)	
D.	Estimated Project Cost (A + B + C)	7,005,791
E.	CON Filing Fee	15,764
F.	Total Estimated Project Cost (D + E)	7,021,555

2. Identify the funding sources for this project.

a. Please check the applicable item(s) below and briefly summarize how the project will be financed. (Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)

___ A. Commercial Loan -- Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions.

___ B. Tax - Exempt Bonds -- Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance.

___ C. General obligation bonds -- Copy of resolution from issuing authority or minutes from the appropriate meeting.

___ D. Grants -- Notification of intent form for grant application or notice of grant award.

___ E. Cash Reserves - Appropriate documentation from Chief Financial Officer.

_X_ F. Other - Identify and document funding from all other sources.

Response

The project will be funded by continuing operations of *Erlanger Health System*. A letter from the CFO is attached to this CON application.

3. Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services And Development Agency.

Response

Cost per square foot for hospital construction is shown below for HSDA approved projects from 2012 - 2014.

HSDA -- Hospital Construction Cost Per Square Foot Approved Projects -- 2012 - 2014			
	Renovated Construction	New Construction	Total Construction
1st Quartile	$ 110.98 / SF	$ 224.09 / SF	$ 156.78 / SF
Median	$ 192.46 / SF	$ 259.56 / SF	$ 227.88 / SF
3rd Quartile	$ 297.82 / SF	$ 296.52 / SF	$ 298.66 / SF

The construction cost for the Level III NICU at *Erlanger East Hospital* is estimated to be $ 3,551,783 for the 8,805 square feet of new construction. This yields a cost per square foot of $ 403.38. The cost is higher than the three (3) year average due to the complexity of construction associated with the establishment of a NICU.

The instant application for the Level III NICU requires a very high level of construction compared to general medical/surgical acute care space. Further, construction costs have increased about 8-10% in 2015 alone. The architect letter which is attached to this CON application has certified the estimated construction cost.

4. Complete Historical and Projected Data Charts on the following two pages - *Do not modify the Charts provided or submit Chart substitutions* ! Historical Data Chart represents revenue and expense information for the last *three* (3) years for which complete information is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections for the *Proposal Only* (i.e.-if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).

Response

The *Historical Data Chart* and *Projected Data Chart* have been completed. The detail for *Other Expenses* on the *Historical Data Chart* is attached to this CON application.

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in ___July___ (Month).

		Year – 2013	Year – 2014	Year – 2015
A.	Utilization Data	29,066	30,394	33,340
	(Specify Unit Of Measure) I/P Admits			
B.	Revenue From Services To Patients			
	1. Inpatient Services	951,407,744	1,011,698,242	1,182,962,344
	2. Outpatient Services	638,832,332	723,658,840	830,030,436
	3. Emergency Services	122,125,184	147,183,286	171,845,957
	4. Other Operating Revenue	33,499,831	36,036,026	32,126,111
	(Specify) Home Health, POB Rent, etc.			
	Gross Operating Revenue	1,745,865,091	1,918,576,394	2,216,964,846
C.	Deductions From Operating Revenue			
	1. Contractual Adjustments	997,920,752	1,105,607,716	1,317,441,010
	2. Provision For Charity Care	102,150,881	110,213,778	92,392,901
	3. Provision For Bad Debt	74,808,470	84,222,955	93,878,274
	Total Deductions	1,174,880,103	1,300,044,449	1,503,712,185
	NET OPERATING REVENUE	570,984,988	618,531,945	713,252,663
D.	Operating Expenses			
	1. Salaries And Wages	275,109,764	276,229,682	270,118,412
	2. Physician's Salaries And Wages	36,117,461	42,290,749	76,375,201
	3. Supplies	78,028,042	82,925,430	93,104,628
	4. Taxes	536,994	566,101	558,754
	5. Depreciation	27,373,556	26,732,222	25,647,102
	6. Rent	5,341,116	5,209,326	5,816,951
	7. Interest – Other Than Capital	0	0	0
	8. Management Fees:			
	a. Fees To Affiliates			
	b. Fees To Non-Affiliates			
	9. Other Expenses	156,440,656	166,565,645	193,745,905
	(Specify) Insurance, Purch. Svcs., etc.			
	Total Operating Expenses	578,947,589	600,519,155	665,366,953
E.	Other Revenue (Expenses) - Net			
	(Specify)			
	NET OPERATING INCOME (LOSS)	(7,962,601)	18,012,789	47,885,710
F.	Capital Expenditures			
	1. Retirement Of Principal	7,900,842	8,048,272	15,492,190
	2. Interest	8,971,728	8,258,717	9,507,644
	Total Capital Expenditures	16,872,570	16,306,989	24,999,834
	NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	(24,835,171)	1,705,800	22,885,876

PROJECTED DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in July (Month).

		Year 1	Year 2
A.	Utilization Data	2,920	2,920
	(Specify Unit Of Measure) NICU Patient Days		
B.	Revenue From Services To Patients		
	1. Inpatient Services	13,083,166	13,698,075
	2. Outpatient Services		
	3. Emergency Services		
	4. Other Operating Revenue		
	Gross Operating Revenue	13,083,166	13,698,075
C.	Deductions From Operating Revenue		
	1. Contractual Adjustments	8,444,524	8,936,645
	2. Provision For Charity Care	1,164,762	1,232,641
	3. Provision For Bad Debt	97,064	102,720
	Total Deductions	9,706,350	10,272,006
	NET OPERATING REVENUE	3,376,816	3,426,069
D.	Operating Expenses		
	1. Salaries And Wages	1,846,194	1,925,580
	2. Physician's Salaries And Wages		
	3. Supplies	192,366	198,522
	4. Taxes		
	5. Depreciation	620,477	620,477
	6. Rent		
	7. Interest - Other Than Capital		
	8. Management Fees:		
	a. Fees To Affiliates		
	b. Fees To Non-Affiliates		
	9. Other Expenses	277,585	261,604
	(Specify) Service Contracts		
	Total Operating Expenses	2,936,622	3,006,183
E.	Other Revenue (Expenses) – Net		
	(Specify)		
	NET OPERATING INCOME (LOSS)	440,194	419,887
F.	Capital Expenditures		
	1. Retirement Of Principal		
	2. Interest		
	Total Capital Expenditures		
	NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	440,194	419,887

5. **Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.**

Response

Following are the average charge amounts per patient.

Average Gross Charge	$ 33,643
Average Deduction From Revenue	$ 25,034
Average Net Revenue	$ 8,609
Average Deduction From Revenue	
Medicare	$ N/A
TennCare / Medicaid	$ 25,667
Average Net Revenue	
Medicare	$ N/A
TennCare / Medicaid	$ 6,888

6. A. **Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges of projects that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.**

Response

Please see the list of average patient charges by service line for *Erlanger East Hospital* and similar hospitals in Hamilton County, Tennessee, for the calendar year 2014, attached to this CON application. Applicant does revise it's patient charge structure on a periodic basis (i.e.- usually annually) during the budget cycle each fiscal year. However, applicant does not anticipate any changes to existing patient charges specifically as a result of this project.

B. **Compare the proposed charges to those of other facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services And Development Agency. If applicable, compare the**

proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Response

Please see the list of average patient charges by inpatient service line for *Erlanger East Hospital* and similar hospitals in Hamilton County, Tennessee, for the calendar year 2013, attached to this CON application. The average patient charge for each hospital is as follows.

Erlanger East Hospital	$ 9,088
Memorial Hospital - Hixson	$ 25,143
Parkridge East Hospital	$ 29,282

Notes
(1) Information derived from Tennessee Hospital Association Market Data for CY 2013.

7. Discuss how projected utilization rates will be sufficient to maintain cost effectiveness.

Response

Historically, *Erlanger East Hospital* has been very cost efficient within the context of the overall healthcare delivery system. The inpatient net revenue per admission for similar hospitals in Chattanooga, Tennessee, is as follows.

Hospital	Avg. Net Revenue Per I/P Admission
Erlanger East Hospital	$ 6,019
Memorial Hospital - Hixson	$ 5,671
Parkridge East Hospital	$ 7,709

Notes
(1) Information derived from Tennessee Joint Annual Reports for CY 2014.

The inpatient average total charge per admission for *Obstetric* services at local community hospitals in Chattanooga, Tennessee, is as follows.

Hospital	Avg. Total Charge Per I/P Admission
Erlanger East Hospital	$ 7,957
Parkridge East Hospital	$ 13,732

Notes
(1) Information derived from Tennessee Hospital Association market data for CY 2013.

8. Discuss how financial viability will be ensured within two (2) years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.

Response

As demonstrated by the *Projected Data Chart*, the project is financially viable in both years 1 and 2.

9. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.

Response

Erlanger East Hospital, as a member facility of *Erlanger Health System*, currently participates in the following Federal / State programs.

Federal	Medicare
State	BlueCare
	TennCare Select
	AmeriGroup Community Care

Anticipated revenue (gross charges) from Federal and State sources during year 1 of the project, is as follows.

Medicare	$ N/A
TennCare	$ 3,425,890
	$ 3,425,890

10. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility-10.

Response

Copies of the following financial statements for *Erlanger Health System* are attached to this CON application.

Interim Balance Sheet & Income Statement	Sep. 30, 2015
Audited Financial Statements	June 30, 2015

11. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to,

A. A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If developments of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.

Response

The service area for this project is defined as Hamilton County, Tennessee, and counties that surround Hamilton County in Tennessee, Georgia, Alabama and North Carolina. This service area comprises a total of 30 counties in its 4 state geography. A complete listing of the service area by county is attached to this CON application.

The need for the Level III NICU on the campus of *Erlanger East Hospital* is brought about by, 1.) the institutional need associated with increased NICU utilization at *Children's Hospital @ Erlanger*, 2.) a quantifiable need when evaluating the CON standard for NICU services in the service area, and 3.) implementation of a transitional neonatal program that allows newborns to be placed in the most appropriate setting … whether with the mother, in a Level II nursery or a Level III NICU depending on clinical need.

Within the service area, there are a total of 90 NICU beds that can serve Level III patients; they are at *Children's Hospital @ Erlanger* (64 beds), Chattanooga, TN; *Parkridge East Hospital* (22 beds), East Ridge, TN; and *Hamilton Medical Center* (4 beds), Dalton, GA. There are a total of 20 NICU beds that can serve Level II patients; they are at *Athens Regional Medical Center* (11 beds), Athens, Tennessee; *Skyridge Medical Center* (3 beds), Cleveland, Tennessee; and *Erlanger East Hospital* (6 beds), Chattanooga, Tennessee. This is a total of 110 neonatal beds in the defined service area.

Applicant can demonstrate that the NICU services available at *Erlanger East Hospital* and *Children's Hospital @ Erlanger* are not "interchangeable" with NICU services available at other hospitals in the service area. By this, it is meant that Erlanger's NICU service is where the other NICU providers send high acuity newborn's which they cannot treat due to skill level limitations, and also due to the complete range of pediatric specialist's at *Children's Hospital @ Erlanger*.

The institutional need is derived, in part, from utilization analysis of the Level III NICU at *Children's Hospital @ Erlanger*, following is a summary for the last three (3) years.

Calendar Year	Average Daily Census	Occupancy
2012	44.0	78.6 %
2013	43.2	77.1 %
2014	52.8	94.3 %

Following is a summary of the Level III NICU utilization at Children's Hospital @ Erlanger for 2015, by month.

Average

Month Of 2015	Daily Census	% Occupancy
January	54.4	97.7 %
February	53.8	96.1 %
March	58.4	104.3 %
April	60.5	108.0 %
May	62.2	111.1 %
June	62.0	110.7 %
July	56.6	101.1 %
August	57.7	103.0 %
September	60.2	107.5 %
October	53.7	95.9 %
November	66.4	118.6 %
December	70.3	125.5 %

Notes
(1) Occupancy for the NICU is calculated based on 56 NICU beds with permanent monitoring equipment.

In the NICU at *Children's Hospital @ Erlanger* the "effective capacity" of this unit is 56 beds, although 64 beds are licensed. This is the number of beds which have a "permanent monitor". However, due to the increased need for the NICU service, eight (8) additional beds have been set up with mobile monitoring equipment due to space constraints within the NICU unit.

As can be seen, utilization for the Level III NICU at *Children's Hospital @ Erlanger* frequently exceeds the 56 bed "capacity". The size and space limitations will be addressed with the replacement of *Children's Hospital @ Erlanger*, which is currently being planned. The Level III NICU at Erlanger East Hospital will allow clinically appropriate newborns to be served by that unit, which is also to be managed by *Children's Hospital @ Erlanger*.

The service area has a total number of projected live births in 2019 of 15,670. The number of NICU beds required is 126. This is derived by multiplying the number of NICU beds required per thousand live births times the number of thousand live births (8 beds x 15.7 = 126). The number of needed beds is determined by subtracting the number of beds required from the number of beds currently available. Therefore, the number of NICU beds needed is 16 (126 - 110 = 16). This CON application seeks to add ten (10) Level III NICU beds at *Erlanger East Hospital*. Six (6) beds will be added to the existing Level II unit at *Erlanger East Hospital*.

In light of this information, the best alternative for *Erlanger Health System* is to initiate a Level III NICU service at *Erlanger East Hospital*.

As *the* safety net hospital in Southeast Tennessee, it is vital that *Erlanger Health System* enhance and update its facilities to provide the best and most accessible services available for the communities we serve. As an academic medical center affiliated with the University of Tennessee College of Medicine, which is co-located on the *Erlanger Medical Center* campus, *EHS* also seeks to provide appropriate facilities so as to enhance the training and education of medical residents and fellows as well as other health professionals. Updating facilities also means planning for tomorrow with regard for the regional service area, ensuring that the needs of the uninsured and/or low income population are being met.

B. The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.

Response

As previously discussed, *Children's Hospital @ Erlanger* will be adding a nine (9) bed NICU "pod" in renovated space, and this project is not reviewable. We could attempt to add additional NICU beds to *Children's Hospital @ Erlanger*, but the concern is that spatial constraints would not provide the best operating environment for this vulnerable population. Therefore, the best option is simply to initiate a Level III NICU service at *Erlanger East Hospital*.

As *the* safety net hospital in Southeast Tennessee, it is vital that *Erlanger Health System* enhance and update its facilities to provide the best and most services available for the communities we serve. As an academic medical center affiliated with the University of Tennessee College of Medicine, which is co-located on the *Erlanger Medical Center* campus, *EHS* also seeks to provide appropriate facilities so as to enhance the training and education of medical residents and fellows as well as other

health professionals. Updating facilities also means planning for tomorrow with regard for the regional service area, ensuring that the needs of the uninsured and/or low income population are being met.

(III.) *CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE*

1. List all health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.

Response

The most significant relationship between this proposal and the existing healthcare system is that it will be part of *Erlanger Health System* and it's ability to integrate the Level III NICU service within the regional service area as the safety net provider, trauma center and region's only academic medical center.

By providing these services regardless of a patient's ability to pay, the regional healthcare delivery system is positively impacted by the services envisioned in the instant application. Further, it provides better access to NICU services for patients that may otherwise have difficulty obtaining such services.

The applicant currently has transfer arrangements with the following hospitals which are owned by *Erlanger Health System*.

-- Erlanger Medical Center
-- Erlanger North Hospital
-- Children's Hospital @ Erlanger
-- Erlanger Bledsoe Hospital

Further, Erlanger currently has patient transfer agreements in place with more than 60 hospitals and other providers in the four (4) state area. These providers refer patients to *Erlanger* because of the depth and breadth

of its programs and services. A copy of the list of transfer agreements is attached to this CON application.

2. **Describe the positive and / or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.**

Response

The effects of this proposal will be positive for the healthcare system because it will deliver the most appropriate level of care for those who are in need of service regardless of ability to pay, and will also distribute needed services across the service area to foster improved patient access. By providing this NICU service the regional healthcare delivery system is positively impacted by serving as the "safety net" for those who are otherwise in need of this highly specialized service.

3. **Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTE's for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the *Tennessee Dept. Of Labor & Workforce Development* and/or other documented sources.**

Response

Clinical staffing for the Level III NICU at *Erlanger East Hospital* is anticipated to be 14.4 R.N.'s and 4.4 unlicensed FTE's, primarily administrative support for the unit. Appropriate salary comparison data is below.

Position	EHS Avg.	Market Mid-Point
RN	$ 24.85	$ 27.77
Unit Clerk	$ 13.55	$ 12.81

NOTES

(1) EHS data is derived from the internal records of *Erlanger Health System*.
(2) The market mid-point is derived from the 2015 Mercer IHN Salary Survey.

4. Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Dept. Of Health, the Dept. Of Mental Health & Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.

Response

Since this project will involve the rotation of NICU staff members from *Children's Hospital @ Erlanger*, it is not anticipated that there will be any difficulty in obtaining additional personnel which may be needed. Due to cross training the skills of these staff members are transferable between locations and considered to be part of their core competency.

However, if it is necessary to recruit personnel for this project, the human resources required will be approached with a proactive recruitment action plan. Historically, *Erlanger* has met staffing requirements by utilizing a variety of methods. Thus, our approach to fulfill the staffing plan will consist of a proactive plan of marketing, screening, hiring, and training.

The Human Resources Department at *Erlanger* will work closely with managers in the transition. The specifics will be based on the needs of the organization and aligned with the strategic initiative of *Erlanger East Hospital*. *Erlanger* has actively been involved in the WorkForce Development movement on several different levels within the Chattanooga area and statewide. Current vacancy rates are below state and national averages.

Erlanger Health System participates with numerous schools that provide advanced training in the areas of nursing and allied health. Therefore, *Erlanger* expects no difficulty in recruitment of required staff given it's role as an academic medical center and it's affiliations with colleges and universities offering allied health and related training programs.

5. **Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review *policies and programs, record keeping, and staff education*.**

Response

The Applicant has reviewed and intends to comply with all licensing and certification requirements imposed by applicable statutes and regulations.

6. **Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).**

Response

Erlanger Health System, as the region's only academic medical center, has established strong long term relationships with the region's colleges, universities and clinical programs. *Erlanger* provides clinical sites for internships and rotation programs in nursing, radiology, respiratory, pharmacy and surgery technology, to name a few.

A number of regional universities offer Bachelor degree programs in nursing and physical therapy. *Erlanger* works closely with the University of Tennessee at Chattanooga to assist nurses transitioning from RN to BSN. Erlanger provides a teaching environment for staff as well with various on-the-job training opportunities (ex: CT for Radiologic Technologist, Certification for LPNs). Locally, two year degrees are available in many clinical allied health areas with additional programs offering advanced technical training in Radiological Imaging such as Nuclear Medicine, Diagnostic Ultrasonography, etc. *Erlanger Health System* participates with numerous schools that provide advanced training in the areas of nursing and allied health.

Erlanger has established strong long term relationships with the region's colleges, universities and clinical programs. *Erlanger* provides clinical sites for internships and rotation programs in nursing, radiology, respiratory care and pharmacy, to name a few. A number of regional universities offer Bachelor degree programs in nursing and physical therapy. Locally, two year degrees are available in many clinical allied health areas with additional programs offering advanced technical training in Radiological Imaging such as Nuclear Medicine and Diagnostic Ultrasonography.

The *University of Tennessee - College of Medicine* is co-located at Erlanger and includes training of senior medical students on clinical rotation as well as graduate medical education for training of residents and advanced fellowships in various medical specialties, including surgical specialties, as outlined below.

Residency Programs

- Emergency Medicine
- Family Medicine
- Internal Medicine
- Obstetrics & Gynecology
- Orthopedic Surgery
- Pediatrics
- Plastic Surgery
- Surgery
- Urology
- Transitional Year

Fellowship Programs

- Orthopedic Trauma Surgery
- Surgical Critical Care
- Vascular Surgery
- Colon & Rectal Surgery
- Emergency Medicine
- Neuro-Interventional Surgery
- Ultrasound
- Cardiovascular Disease
- Gastroenterology (under development)
- Radiology (under development)
- Neurology (under development)

Erlanger Health System also participates with numerous schools that provide advanced training in the areas of nursing and allied health.

7. (a) **Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Dept. Of Health, the Dept. Of Mental Health & Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.**

Response

The Applicant has reviewed and intends to comply with all licensing and certification requirements imposed by applicable statutes and regulations of the Tennessee Dept. Of Health and/or any applicable Medicare requirements.

(b) Provide the name of the entity from which the applicant has received or will receive licensure, certification, and / or accreditation.

Licensure: State of Tennessee, Dept. of Health

Accreditation: The Joint Commission

If an existing institution, please describe the current standing with any licensing, certifying, or accrediting agency or commission. Provide a copy of the current license of the facility.

Response

Erlanger East Hospital, as a satellite facility of *Erlanger Medical Center*, continuously strives to comply with applicable regulations and make needed changes where deficiencies may arise to ensure full compliance. A copy of the current license from the Tennessee Dept. of Health is attached to this CON application. Further, a copy of the most recent *Letter Of Accreditation* from *The Joint Commission* is attached to this CON application.

(c) For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been

addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.

Response

A copy of the most recent licensure/certification inspection report with an approved plan of correction is attached to this CON application.

8. **Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5 % ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.**

Response

This criterion is not applicable because *Erlanger East Hospital*, as a satellite facility of *Erlanger Medical Center*, operates as part of the Chattanooga-Hamilton County Hospital Authority, which is a governmental unit and a statutory entity under the State of Tennessee. As such, it is not possible for there to be any "owners", per se, except for the people of Hamilton County, Tennessee, and the State of Tennessee.

9. **Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5 % ownership interest in the project.**

Response

This criterion is not applicable because *Erlanger East Hospital*, as a satellite facility of *Erlanger Medical Center*, operates as part of the Chattanooga-Hamilton County Hospital Authority, which is a governmental unit and a statutory entity under the State of Tennessee. As such, it is not possible for there to be any "owners", per se, except for the people of Hamilton County, Tennessee, and the State of Tennessee.

10. If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services And Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required.

Response

Applicant will provide the *Health Services And Development Agency* with appropriate information in consideration of this CON application.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of publication of the letter of intent.

Attached is a copy of the *Letter Of Intent* which was filed with the *Tennessee Health Services & Development Agency* on January 8, 2016. The original *Affidavit Of Publication* is also attached to this CON application.

DEVELOPMENT SCHEDULE

Tennessee Code Annotated § 68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for cause shown. Subsequent to granting a Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**

   Response

   The *Project Completion Forecast Chart* has been completed and appears on the following page.

2. **If the response to the preceding question indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph, please state below any request for an extended schedule and document the "good cause" for such an extension.**

   Response

   *** Not Applicable. ***

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision Date, as published in Rule 68-11-1609(c): April 27, 2016

Assuming the CON approval becomes the final Agency action on that date; indicate the number of days from the above agency decision date to each phase of the completion forecast.

PHASE		Days Required	Anticipated Date (MONTH / YEAR)
1.	Architectural and engineering contract signed.	2	04/2016
2.	Construction documents approved by the *Tennessee Dept. Of Health.*	170	12/2016
3.	Construction contract signed.	15	12/2016
4.	Building permit secured.	30	01/2017
5.	Site preparation completed.	60	03/2017
6.	Building construction commenced.	0	03/2017
7.	Construction 40 % complete.	66	06/2017
8.	Construction 80 % complete.	66	09/2017
9.	Construction 100 % complete (approved for occupancy).	30	10/2017
10.	*Issuance of license.	20	11/2017
11.	*Initiation of service.	0	11/2017
12.	Final Architectural Certification Of Payment.	0	11/2017
13.	Final Project Report Form (HF0055).	20	12/2017

(*) For projects that do NOT involve construction or renovation, please complete items 10 and 11 only.

NOTE – If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

A F F I D A V I T

STATE OF TENNESSEE

COUNTY OF HAMILTON

Joseph M. Winick, being first duly sworn, says that he / she is the applicant named in this application or his / her / it's lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Agency Rules, and T.C.A. § 68-11-1601, *et seq*, and that the responses to this application or any other questions deemed appropriate by the Tennessee Health Services & Development Agency are true and complete.

SIGNATURE

SWORN to and subscribed before me this 11 of January (Month), 2016 (Year), a Notary Public in and for the State of Tennessee, County of Hamilton.

Shelia Hall
NOTARY PUBLIC

My commission expires June 9 (Month / Day), 2018.

SHELIA HALL
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY

TABLE OF ATTACHMENTS

Description	Section / Item
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Proof Of Publication

HSDA - Letter Of Intent
HSDA - Publication Of Intent
Affidavit Of Publication

ATTACHMENTS

Description	Section / Item
Secretary Of State Certificate	A-4
Enabling Legislation	A-4

State of Tennessee

Department of State

To all to whom these Presents shall come, Greeting:

I Gentry Crowell, Secretary of State of the State of Tennessee, do hereby certify that the annexed is a true copy of

PRIVATE CHAPTER NO. 125

SENATE BILL NO. 1499

PRIVATE ACTS OF 1977

the original of which is now on file and a matter of record in this office.

In Testimony Whereof, I have hereunto subscribed my Official Signature and by order of the Governor affixed the Great Seal of the State of Tennessee at the Department in the City of Nashville, this 13th day of June A.D. 19 77

Gentry Crowell

Secretary of State

PRIVATE CHAPTER NO. 125

SENATE BILL NO. 1499

By Albright, Ortwein

Substituted for: House Bill No. 1514

By Robinson (Hamilton)

AN ACT To amend Chapter 297 of the 1976 Private Acts of Tennessee entitled "AN ACT To create a Governmental Hospital Authority to own and operate Baroness Erlanger Hospital, T. C. Thompson Children's Hospital and other related facilities and provide for the establishment and organization of a Board of Trustees for the operation thereof," relative to the Board of Trustees of said Hospital Authority and the powers and duties thereof, to the issuance of bonds and other obligations by the authority and the securing thereof, to the Financial Review Committee with respect to the authority, and the duties and powers thereof, and to other provisions with respect to the duties and obligations of the authority, and validating and ratifying said Chapter No. 297 and ratifying all acts of the Board of Trustees of the authority.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Chapter 297 of the Private Acts of 1976 is amended by amending Section 1 thereof to read as follows:

"SECTION 1. A governmental Hospital Authority to be known as the Chattanooga-Hamilton County Hospital Authority, is hereby created and established for and on behalf of Hamilton County, Tennessee, for the purpose of performing a governmental function by operating Baroness Erlanger Hospital and T. C. Thompson Children's Hospital and such other similar or associated hospitals and existing health centers deemed appropriate to be operated by said authority as sole operator for the purpose of providing health care facilities and programs for the residents of Hamilton County, Tennessee."

SECTION 2. Chapter 297 of the Private Acts of 1976 is amended by deleting the first paragraph of Section 2 thereof and by substituting for such paragraph two new paragraphs to read as follows:

"SECTION 2. The Hospital Authority shall be operated upon the tracts and parcels of real property owned jointly by Hamilton County and the City of Chattanooga, Tennessee, and on which are situated the Baroness Erlanger Hospital and the T. C. Thompson Children's Hospital or upon any other real property acquired by the authority through gift and purchase. The city and the county are authorized and directed to convey and assign all real property constituting the Baroness Erlanger Hospital and the T. C. Thompson Children's Hospital to the authority. The city and the county are also authorized to convey and assign all personal property constituting the Baroness Erlanger Hospital and the T. C. Thompson Children's Hospital to the authority.

"In the event the authority shall at any time cease to exist as the operator of Baroness Erlanger Hospital, T. C. Thompson Children's Hospital and such other similar or associated hospitals and existing health centers deemed appropriate to be operated by the authority as sole operator, the real estate which was owned on August 5, 1976, by the county and the city and conveyed to the authority by the county and the city, shall revert in fee simple to the county, subject to such encumbrances as may be on said property at the time of reversion; provided, however, that the city shall have an option to require transfer to it of the title to the same proportion of such real estate as was owned by the city on such date, subject to such encumbrances on that portion of the real estate.

"If the authority shall at any time cease to use any such parcel or parcels of said real estate for hospital or related purposes for a period of two (2) years, then the county and the city shall have the option to require transfer to them of title to such parcel or parcels in fee simple, subject to such encumbrances as may be on said property at the time of such transfer of title, in the same proportion as such parcel or parcels were previously owned by the county and the city. In the event that either the county or the city shall elect not to exercise its option with respect to any such parcel or parcels of real estate, then the other of them shall have the option to require transfer to it of the entire parcel or parcels of real estate in question. In the event that neither the county nor the city decides that they wish to exercise said option, then the authority shall have the right to dispose of such property in whatever manner it deems appropriate."

SECTION 3. Chapter 297 of the Private Acts of 1976 is amended by amending Section 3 thereof to read as follows:

"SECTION 3. Said Hospital Authority shall be operated and controlled by a Board of Trustees consisting of eleven (11) members who shall serve without compensation but who shall be indemnified by the authority for any liability they might incur while acting in such capacity other than from culpable negligence. The original members of the Board of Trustees and their respective terms of office are declared to be those

individuals whose names are set out below, and upon expiration of such terms the members of the Board of Trustees shall be appointed by the county judge of the county, the mayor of the city, the chancellors of the chancery courts, and the legislative delegation for four (4) year terms as provided in the next succeeding paragraph hereof. The following are confirmed as the original members of the Board of Trustees and shall hold office for terms ending as follows (or until their successors are appointed):

Name of Trustee	Successor to be Appointed by	Term of Office Expires
David P. McCallie, M.D.	Mayor	11-1-80
Mrs. Vi Ketchersid	County Judge	11-1-80
Stan Guthrie	Chancellors	11-1-80
Harry W. McKaldin, Jr.	Mayor	11-1-79
Robert Brewer, Jr.	County Judge	11-1-79
Don J. Russell, M.D.	Mayor and County Judge (with approval of medical society)	11-1-79
J. K. Lawrence	Mayor	11-1-78
John C. Cantrill	County Judge	11-1-78
Claude Ramsey	Legislative Delegation	11-1-78
Charles Griffin	Mayor	11-1-77
Forrest Cate	County Judge	11-1-77

"The method of appointment of the members of the Board of Trustees after the expiration of the terms of the original members of such board shall be as follows: The mayor of the city shall appoint four (4) trustees, with the approval of a majority of the members of the Board of Commissioners. The county judge of the county shall appoint four (4) trustees, with the approval of a majority of the members of the county council. Said mayor and county judge shall jointly appoint one (1) trustee with the approval of the president of the Chattanooga-Hamilton County Medical Society, Inc., acting with the approval of a majority of the House of Delegates of said society, and with the approval of a majority of the members, respectively, of the Board of Commissioners and of the county council. The chancellors of chancery court shall jointly appoint one (1) trustee. The legislative delegation shall by a majority vote appoint one (1) trustee.

"Upon the expiration of the term of office of any trustee, his successor shall be appointed for a term of four (4) years by the authority appointing the trustee whose term has expired. The original trustees, for all purposes of this section, shall be considered to have been appointed by the mayor, the county judge, the chancellors and/or the legislative delegation as indicated in the above tabulation.

"All such appointments to the Board of Trustees as provided herein shall be made without regard to religious preference, race, sex or national origin, and in the making of appointments due consideration shall be given to making said Board of Trustees representative, as nearly as may be practicable, of all residents of the city and county, including the various racial groups therein.

"Any member so appointed to the Board of Trustees may, for reasonable cause, be removed from his or her office in the same manner and by the same authority as such member was appointed to the office; provided that such removal shall be preceded by a full hearing and adequate notice of such hearing. 'Reasonable cause' shall include, but shall not be limited to, misconduct in office, failure to perform duties prescribed by this act or other applicable law, or failure to diligently pursue the objectives for which the authority was created.

"Vacancies on the Board of Trustees caused by any reason whatsoever, shall be filled by appointment of the authority who appointed the trustee vacating the office, but without the necessity of approval otherwise herein required. A trustee so appointed shall hold office for the remainder of the term of the trustee vacating the office.

"A member of the Board of Trustees may serve as such trustee for not more than eight (8) consecutive years, excluding any previous service as a member of the Board of Trustees of Baroness Erlanger Hospital and/or T. C. Thompson Children's Hospital."

The occupancy of their respective offices by the present members of the Board of Trustees (being those individuals enumerated in amended Section 3 above) is hereby ratified and confirmed.

SECTION 4. Chapter 297 of the Private Acts of 1976 is amended by repealing Section 4 thereof and substituting therefor a new Section 4 to read as follows:

"SECTION 4. Whenever used in this act, unless a different meaning clearly appears from the context, the following terms whether used in the singular or the plural shall be given the following respective interpretations:

'Authority' or 'Hospital Authority' means the Chattanooga-Hamilton County Hospital Authority as created by this act.

"Board of Commissioners" means the Board of Commissioners of the city.

"Board of Trustees" means the Board of Trustees of the authority as provided for in this act.

"Bonds" means bonds of the authority authorized to be issued by this act. "Advance refunding bonds" means bonds issued for the purpose of refunding outstanding bonds which will neither mature by their terms nor be subject to and called for redemption within a period of 30 days following the date of issuance of said advance refunding bonds.

"Chancellors" means the Chancellors of the Chancery Courts of Hamilton County, Tennessee.

"Chief Executive Officer" means, as the context requires, the president of the authority, the mayor of the city, and the county judge of the county.

"City" means the City of Chattanooga, Tennessee.

"County" or "Hamilton County" means Hamilton County, Tennessee.

"County Council" means the county council of the county.

"County Judge" means the county judge or such other chief executive officer of the county as may be created by subsequent law.

"Financial Review Committee" means the Financial Review Committee provided for in this act.

"Hamilton County Sales Tax Agreement" means the agreement between the city and the county, dated March 23, 1966.

"Legislative Delegation" means the Hamilton County delegation to the Legislature of Tennessee, being the Senators and Representatives elected from those districts lying in whole or in part in the county.

"Mayor" means the mayor of the city or such other chief executive officer of the city as may be created by subsequent law.

"Notes" means notes of the authority authorized to be issued by this act. "Short-Term Notes" means nonrenewable notes having a term no longer than three (3) years. "Long-Term Notes" means renewable short-term notes and notes having a term longer than three (3) years.

"Project" or "Facility" shall mean any one or combination of buildings, structures or facilities owned by the authority, including the site therefor and all machinery and equipment therein or necessary to the operation thereof, and shall include expressly the Baroness Erlanger Hospital and the T. C. Thompson Children's Hospital."

SECTION 5. Chapter 297 of the Private Acts of 1976 is amended by repealing Section 5 thereof and by renumbering Section 6 thereof as Section 5.

SECTION 6. Chapter 297 of the Private Acts of 1976 is amended by renumbering Section 7 thereof as Section 6 and by amending said renumbered Section 6 to read as follows:

"SECTION 6. The Board of Trustees shall be vested with the full, absolute and complete authority and responsibility for the complete operation, management, conduct and control of the business and affairs of the Hospital Authority herein created. This authority and responsibility shall include, but shall not be limited to, the establishment, promulgation and enforcement of the rules, regulations and policies of the authority, the granting of or the refusal of medical staff privileges, the upkeep and maintenance of all property, the administration of all financial affairs of the authority, including pledging of assets for expansion and improvement of facilities and any other necessary financial needs of the authority. The authority shall have, but shall not be limited to, the following powers together with all powers incidental thereto or necessary for the performance of those hereinafter stated: (1) to sue and be sued and to prosecute and defend, at law or in equity, in any court having jurisdiction of the subject matter and of the parties; (2) to have and use an official seal and to alter the same at pleasure; (3) to acquire, whether by purchase, construction, exchange, gift, lease, or otherwise, and to improve, maintain, extend, equip and furnish hospital and related facilities within the corporate limits of Hamilton County, including expressly, but without limitation, professional office buildings, ancillary residence facilities and data processing facilities, and including all real and personal properties which the Board of Trustees may deem necessary in connection therewith and regardless of whether or not any such facilities shall then be in existence; (4) to execute all contracts, agreements and other instruments with any person, partnership, corporation, federal, state, county or municipal government, including but not limited to the issuance of bonds, mortgages, notes and other forms of indebtedness, and contracts for the

management of hospital and clinic facilities (but no such management contract shall exceed two (2) years in length); (5) subject to the provisions of Section 2 hereof, to sell, lease, exchange, donate, and convey any or all of its properties whenever its Board of Trustees shall find any such action to be in furtherance of the purposes for which the authority was created; (6) to borrow money and issue its bonds and notes for the purpose of carrying out any of its powers; (7) as security for the payment of the principal of and interest on any bonds and notes so issued and any agreements made in connection therewith, to mortgage and pledge any or all of its facilities or any part or parts thereof, whether then owned or thereafter acquired, and to pledge all or any portion of the revenues and receipts therefrom or from any thereof; (8) to employ and pay compensation to such employees, and agents, including attorneys, accountants, engineers, architects and financial consultants, as the Board of Trustees shall deem necessary for the business of the authority; and (9) to establish bylaws and make all rules and regulations not inconsistent with the provisions of this act, deemed expedient for the management of the authority's affairs.

"No contract, except for personal services or lease obligations, involving an expenditure exceeding one thousand dollars ($1,000.00), nor several proposed contracts aggregating more than one thousand dollars ($1,000.00), for the same general work or kind of work, supplies or equipment, shall be awarded until after at least one advertisement in some newspaper of general circulation published in the county at least ten (10) days before such contract is awarded or supplies purchased, and then only to the lowest and best bidder. Said bids shall be sealed and filed with the president or his designee, who shall publicly open them on the date specified and not prior thereto. No entire project or purchase involving the same type of work, equipment or supplies shall be split into small contracts. Nothing in this paragraph shall be construed to apply to the issuance of bonds or notes by the authority.

"Purchases and contracts involving an expenditure of not more than one thousand dollars ($1,000.00) shall be made in conformity with the rules and regulations adopted by the Board of Trustees.

"The authority shall prescribe reasonable rates, fees and charges for the services and

facilities furnished by the authority and shall revise such rates, fees and charges from time to time so as to produce revenue at least sufficient to pay the principal of and interest on all bonds and other obligations issued by the authority, including reserves therefor, and to pay the cost of maintaining and operating its facilities."

SECTION 7. Chapter 297 of the Private Acts of 1976 is amended by the addition of a new Section 7 thereto to read as follows:

"SECTION 7. Except as herein otherwise expressly provided, all bonds issued by the authority shall be payable solely out of and secured by a pledge of all or any portion of the revenues and receipts derived from the authority's projects or of any thereof as may be designated in the proceedings of the Board of Trustees under which such obligations shall be authorized to be issued and may be secured by a mortgage or deed of trust covering all or any part of the projects from which the revenues and receipts so pledged may be derived, as such projects may thereafter be extended or enlarged; provided, that notes issued in anticipation of the issuance of bonds may be retired out of the proceeds of such bonds. The proceedings under which the bonds are authorized and any such mortgage or deed of trust may contain agreements and provisions respecting the maintenance of the facilities covered thereby, the establishment of rates, fees and charges for the services and facilities furnished by the authority, the creation and maintenance of special funds from the revenues of the authority and the rights and remedies available in the event of default, all as the Board of Trustees shall determine advisable and not in conflict with the provisions of this act. Each pledge, mortgage and deed of trust made for the benefit or security of any bonds of the authority shall continue in effect until the principal of and interest on the bonds for the benefit of which the same were made shall have been fully paid. In the event of default in such payment or in any agreement of the authority made as a part of the contract under which the bonds were issued, whether contained in the proceedings authorizing the bonds or in any mortgage or deed of trust executed as security therefor, such payment or agreement may be enforced by suit, mandamus, the appointing of a receiver in equity or by foreclosure of any such mortgage or deed of trust, or any one or more of such remedies.

"Such bonds may be executed and delivered by the authority at any time and from time to time, may be in such form and denominations and of such terms and maturities, may be subject to redemption prior to maturity either with or without premium, may be in fully registered form or in bearer form registrable either as to principal or interest or both, may bear such conversion privileges and be payable in such installments and at such time or times not exceeding forty (40) years from the date thereof, may be payable at such place or places whether within or without the State of Tennessee, may bear interest at such rate or rates payable at such time or times and at such place or places and evidenced in such manner, may be executed by such officers of the authority, and may contain such provisions not inconsistent herewith, all as shall be provided in the proceedings of the Board of Trustees whereunder the bonds shall be authorized to be issued. Any bonds of the authority may be sold at public or private sale for such price and in such manner and from time to time as may be determined by the Board of Trustees to be most advantageous, and the authority may pay all expenses, premiums and commissions which its Board of Trustees may deem necessary or advantageous in connection with the issuance thereof.

"Proceeds of bonds and notes issued by the authority may be used for the purpose of constructing, acquiring, reconstructing, improving, equipping, furnishing, bettering, or extending any project or projects, including the payment of interest on the bonds during construction of any such project and for six (6) months after the estimated date of completion, the payment of engineering, fiscal, architectural, bond insurance and legal expenses incurred in connection with such project and the issuance of the bonds, and the establishment of a reasonable reserve fund for the payment of principal of and interest on such bonds in the event of a deficiency in the revenues and receipts available for such payment. Any bonds and long-term notes shall, except as herein otherwise expressly provided, be issued for capital expenditures and none of the proceeds shall be used for operational expenditures or routine maintenance needs.

"Except as hereinafter in this paragraph provided, the amount of bonds and notes of the authority which may be issued at any time, together with any bonds and notes of the authority then outstanding, shall not exceed an amount equal to ninety percent (90%) of the sum of the value of the existing plant, property and equipment of the authority at the time of issuance of such bonds plus the contract price of the improvements to be constructed, acquired and installed from the proceeds of such bonds, less (1) the principal amount outstanding, if any, of such bonds as may have been issued by the county for the expansion, remodeling, repairing, equipping, and/or construction of all or any part of Baroness Erlanger Hospital and/or T. C. Thompson Children's Hospital, and (2) the amount, if any, of any unfunded portion of the employees' pension fund of Baroness Erlanger Hospital and/or T. C. Thompson Children's Hospital. Plant, property and equipment for the purpose of the preceding sentence shall be stated at market value as determined by a professional appraiser to be selected by the Financial Review Committee. A certificate of such professional appraiser with respect to the value of such plant, property and equipment, a certificate of the county judge of the county with respect to the amount of outstanding bonds of the county for such hospital purposes, and a certificate of the chief executive officer of the authority with respect to the unfunded portion of such employees' pension fund shall each be conclusive for the purposes of determining the amount of bonds and notes which may be issued pursuant to this paragraph. The limitations expressed in this paragraph shall not apply to the issuance of advance refunding bonds.

"The Board of Trustees shall direct in the proceedings authorizing the issuance of any bonds of the authority that there shall be set aside and appropriated as a reserve for the payment of principal and interest on said bonds an amount not less than the required amount of principal and interest on the bonds falling due during the 12 month period next succeeding the date of issuance of the bonds.

"Any bonds or notes of the authority at any time outstanding may at any time and from time to time be refunded by the authority by the issuance of its refunding bonds in such amount as the Board of Trustees may deem necessary, but not exceeding the sum of the following: (a) the principal amount of the obligations being refinanced; (b) applicable redemption premiums thereon; (c) unpaid interest on such obligations to the date of delivery or exchange of the refunding bonds; (d) in the event the proceeds from the sale of the refunding bonds are to be deposited in trust

as hereinafter provided, interest to accrue on such obligations from the date of delivery to the first or any subsequent available redemption date or dates selected, in its discretion, by the Board of Trustees, or to the date or dates of maturity, whichever shall be determined by the Board of Trustees to be most advantageous or necessary to the authority; and (e) expenses, premiums and commissions of the authority, including bond discount, deemed by the Board of Trustees to be necessary for the issuance of the refunding bonds. A determination by the Board of Trustees that any refinancing is advantageous or necessary to the authority, or that any of the amounts provided in the preceding sentence should be included in such refinancing, or that any of the obligations to be refinanced should be called for redemption on the first or any subsequent available redemption date or permitted to remain outstanding until their respective dates of maturity, shall be conclusive.

"Any such refunding may be effected either by the exchange of the refunding bonds for the obligations to be refunded thereby with the consent of the holders of the obligations so to be refunded, or by sale of the refunding bonds and the application of the proceeds thereof to the payment of the obligations to be refunded thereby, in the manner herein provided.

"Prior to the issuance of the refunding bonds, the Board of Trustees shall cause notice of its intention to issue the refunding bonds, identifying the obligations proposed to be refunded and setting forth the estimated date of delivery of the refunding bonds, to be given to the holders of the outstanding obligations by publication of an appropriate notice one (1) time each in a newspaper having general circulation in Hamilton County and in a financial newspaper published in New York, New York, and having national circulation. As soon as practicable after the delivery of the refunding bonds, and whether or not any of the obligations to be refunded are to be called for redemption, the Board of Trustees shall cause notice of the issuance of the refunding bonds to be given in the manner provided in the preceding sentence.

"If any of the obligations to be refunded are to be called for redemption, the Board of Trustees shall cause notice of redemption to be given in the manner required by the proceedings authorizing such outstanding obligations.

"The principal proceeds from the sale of any refunding bonds shall be applied only as follows: either,

(a) to the immediate payment and retirement of the obligations being refunded; or

(b) to the extent not required for the immediate payment of the obligations being refunded then such proceeds shall be deposited in trust to provide for the payment and retirement of the obligations being refunded and to pay any expenses incurred in connection with such refunding, but provision may be made for the pledging and disposition of any surplus, including, without limitation, provision for the pledging of any such surplus to the payment of the principal of and interest on any issue or series of refunding bonds. Money in any such trust fund may be invested in direct obligations of, or obligations the timely payment of principal of and interest on which are fully guaranteed by the United States government, or obligations of any agency or instrumentality of the United States government, or in certificates of deposit issued by a bank or trust company located in the State of Tennessee if such certificates shall be secured by a pledge of any of said obligations having an aggregate market value, exclusive of accrued interest, equal at least to the principal amount of the certificates so secured. Nothing herein shall be construed as a limitation on the duration of any deposit in trust for the retirement of obligations being refunded but which shall not have matured and which shall not be presently redeemable or, if presently redeemable, shall not have been called for redemption."

SECTION 8. Chapter 297 of the Private Acts of 1976 is amended by adding at the end of the third paragraph of Section 9 thereof a new sentence to read as follows:

"A certificate by such actuary with respect to the currency of such required pension fund contributions shall be conclusive for the purpose of determining compliance by the authority with the provisions of this section."

SECTION 9. Chapter 297 of the Private Acts of 1976 is amended by adding a new sentence to the end of Section 10 thereof, said new sentence to read as follows:

"Notwithstanding the foregoing provisions of this section, nothing herein contained shall be construed as limiting any expenditures made by the authority for the payment of principal of and in-

terest on bonds or other obligations issued by the authority."

SECTION 10. Chapter 297 of the Private Acts of 1976 is amended by amending Section 11 thereof to read as follows:

"SECTION 11. A Financial Review Committee shall be created consisting of seven (7) members, one (1) of whom shall be Black. The membership shall be composed of the auditor of the city, the auditor of the county, and five (5) other persons who are residents of Hamilton County, three (3) of whom shall be appointed by the county judge with the approval of a majority vote of the county council and two (2) of whom shall be appointed by the mayor with the approval of a majority vote of the Board of Commissioners; provided, that if any members of such committee shall not have been so appointed within 90 days from the date of approval of this act by the county council of the county, such members shall thereupon be appointed by a majority vote of the members of the legislative delegation.

"The members of the committee shall serve without compensation. They shall be indemnified by the authority for any liability they might incur while acting in such capacity other than for culpable negligence. With the exception of the city auditor and the county auditor, the remaining members shall be initially appointed to staggered terms as follows: two (2) for terms of three (3) years; one (1) to be so appointed by the county judge and one (1) to be so appointed by the mayor; two (2) for terms of two (2) years; one (1) to be so appointed by the county judge and one (1) to be so appointed by the mayor; and one (1) to be so appointed by the county judge for a term of one (1) year. Thereafter, each appointee shall serve for a period of three (3) years and such appointee's successor shall be appointed in the same manner and by the same official who appointed the person whose term has expired. Any person appointed to fill a vacancy for any reason other than expiration of term of office shall be appointed to hold office for the remainder of the term of the member vacating the office. Said vacancy shall be filled in the same manner as the original appointment.

"The Financial Review Committee shall review the proposed issuance of bonds or long-term notes, to consider if the issuance of said obligations is within the fiscal ability of the authority based upon the appropriate preceding annual audits, monthly operating statements subsequent to the closing date of the most recent audit period included in the most recent annual audit, additional revenue projections reasonably anticipated as a result of the proposed capital expenditure (taking into account any probable revenue loss during replacement, if any), and any other data reasonably bearing upon the fiscal soundness of the issuance of such bonds or long-term notes. At such time or times as the Board of Trustees of the authority shall desire to authorize the issuance of bonds or long-term notes it shall first submit the proposal to issue such obligations to the Financial Review Committee, which committee shall file its advisory report thereon with the Board of Trustees within sixty (60) days after the receipt of such proposal. Upon the filing of such report with the Board of Trustees, or after sixty (60) days following the date of submission of such proposal to such committee, whichever is earlier, the Board of Trustees may proceed with the issuance of such bonds or long-term notes; provided, that the submission to the Financial Review Committee herein required shall not be necessary at any time if such committee has not then been validly appointed and is not in existence.

"The Financial Review Committee shall annually review the proposed budget prepared by the Board of Trustees and shall file its report thereon with the Board of Trustees and the County Council.

"All reports of the Financial Review Committee shall be made to the County Council of the county, the Board of Commissioners of the city and the Board of Trustees of the authority, and shall be considered by the respective governing bodies with which such reports are filed."

SECTION 11. Chapter 297 of the Private Acts of 1976 is amended by adding six new sections thereto to be numbered 17 to 22, inclusive, and to read as follows:

SECTION 17. Notwithstanding any other provision of this act the county shall have the option to purchase all real and personal property of the authority if either of the following shall have occurred:

(a) The authority shall have defaulted in the payment when due of principal or interest on any of its bonds or long-term notes then outstanding; or

(b) The authority shall have filed written notice with the county judge that it is the expectation of the Board of Trustees of the authority that the authority will so default in the payment of principal of or interest on any of its bonds or long-term notes then outstanding on the next succeeding date on which such principal or interest shall fall due.

"The purchase price in the event that the county shall elect to exercise any such option shall be an amount equal to the principal of and interest to maturity or the first call date, if any, whichever shall be earlier, together with any applicable premiums, on all bonds and long-term notes of the authority then outstanding, and the amount so received by the authority from the county shall be impressed with a trust in favor of the holders of such bonds and long-term notes and shall be used for the payment of principal of and interest and redemption premiums thereon and for no other purpose.

"Such purchase option of the county shall be superior to any right of foreclosure herein permitted, and any mortgage hereinafter granted by the authority shall recognize and be subject to such option to purchase.

"SECTION 18. The authority is hereby declared to be a public instrumentality acting on behalf of the county, but without the power of eminent domain, and in that connection to be fulfilling a public function, and the authority and all properties at any time owned by it and the income therefrom and all bonds or notes issued by the authority and the income therefrom shall be exempt from all taxation in the State of Tennessee. Also, for purposes of the Securities Law of 1955, compiled as Sections 48-1601 through 48-1648, Tennessee Code Annotated, and any amendment thereto or substitution therefor, bonds or notes issued by the authority shall be deemed to be securites issued by a public subdivision of the State of Tennessee.

"SECTION 19. The authority shall be a public nonprofit corporation and no part of its net earnings remaining after payment of its expenses shall inure to the benefit of any individual, firm or corporation.

"SECTION 20. Neither the county nor the city shall in any event be liable for the payment of the principal of or interest on any bonds or notes of the authority or for the performance of any pledge, mortgage, obligation or agreement of any kind whatsoever which may be undertaken by the authority, and none of the bonds or notes of the authority or any of its agreements or obligations shall be construed to constitute an indebtedness of either the county or the city within the meaning of any constitutional or statutory provision whatsoever.

"SECTION 21. Nothing contained in this act shall be construed to impair any contract rights which may have vested prior to the enactment of this act.

"SECTION 22. It is hereby declared that the purpose of this act is to facilitate adequate hospital facilities for the residents of the county. Bonds may be issued under this act without regard to the requirements, restrictions or procedural provisions contained in any other law."

SECTION 12. Chapter 297 of the Private Acts of 1976 is hereby in all respects ratified and confirmed and said act as herein amended is hereby reenacted by this General Assembly.

SECTION 13. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect any other provisions or application of the act which can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

SECTION 14. This act shall have no effect unless it is approved by a two-thirds vote of the County Council of Hamilton County. Its approval or nonapproval shall be proclaimed by the presiding officer of the county council and certified by such officer to the Secretary of State.

SECTION 15. For the purpose of approving this act as provided in Section 14 it shall take effect on becoming law, the public welfare requiring it, but for all other purposes it shall be effective only upon being approved as provided in Section 14.

SENATE BILL NO. 1499

PASSED: May 19, 1977

SPEAKER OF THE SENATE

SPEAKER OF THE HOUSE OF REPRESENTATIVES

APPROVED this 28th day of May 19 77

GOVERNOR

Description	Section / Item
Erlanger East Hospital - Warranty Deed	A-6

LAWYERS TITLE AND ESCROW, INC.
DOME BUILDING
736 Georgia Avenue
Chattanooga, Tn. 37402
(615) 756-4154

WARRANTY DEED

Prepared by:
ROBERT L. BROWN, Attorne
100 Dome Building
736 Georgia Avenue
Chattanooga, Tn. 37402

BOOK 3553 PAGE 712

FILE NO. 880536
crs

DATE: November 15, 1988

THIS INDENTURE between

JAMES C. HUDSON, JR. AND WIFE, SHARON D. HUDSON,

as party or parties of the first part, hereinafter called Grantor, and

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY, A GOVERNMENTAL HOSPITAL AUTHORITY,

as party or parties of the second part, hereinafter called Grantee (the words "Grantor" and "Grantee" to include the parties named herein and their respective heirs, successors and assigns);

WITNESSETH that Grantor, for and in consideration of the sum of One Dollar and other good and valuable considerations, the receipt whereof is hereby acknowledged, does hereby convey to Grantee in fee simple, the following described property:

All that tract or parcel of land lying and being in the City of Chattanooga, Hamilton County, Tennessee, being a part of the Northwest Quarter of Section 14, Township 2, South, Range 3, West of the Basis Line, Ocoee District and being more particularly described as: Beginning at the intersection of the southern right-of-way of Crane Road (allowing for a width of 50 feet) with the western line of Gunbarrel Road; thence South 23 degrees 00 minutes 35 seconds West along said western right-of-way 1313.76 feet to a point; thence North 66 degrees 22 minutes West 934.73 feet to the southeast corner of Lot 14, Eastover Acres Subdivision, as shown by plat recorded in Plat Book 24, Page 40, in the Register's Office of Hamilton County, Tennessee; thence along the eastern line of Eastover Acres Subdivision, North 22 degrees 56 minutes East 1071.8 feet to a point; thence along the southeastern line of Eastover Acres Subdivision, North 48 degrees 55 minutes East 267.6 feet to a point on the southern right-of-way of Crane Road; thence along said southern right-of-way of Crane Road, South 66 degrees 22 minutes East 819.24 feet to the point of Beginning. Said tract containing 27.89 acres as shown on survey by Alfred L. allen dated October, 1987.

Being the same property conveyed by deeds recorded in Bok 2090, Page 227 and Book 3444, Page 417, said Register's Office.

This conveyance is made subject only to the following:

Sewer easement to City of Chattanooga, recorded in Book 2448, Page 305, said Register's Office.

Utility easement, the center line of which runs along the eastern and southeastern lines of Eastover Acres, as shown by plat recorded in Plat Book 24, Page 40, said Register's Office.

Anchor easement in the southwest corner of the property as shown on said plat.

Address of Grantee	Mail Tax Notice to	Map Parcel No.
Sr. Vice President - Finance Chattanooga-Hamilton County Hospital Authority	SAME	158D-G-27

TO HAVE AND TO HOLD said property and all rights appurtenant thereto, to Grantee forever in FEE SIMPLE.

Grantor warrants that Grantor is lawfully seized and possessed of said property, has full power and lawful authority to convey same, that Grantor's title is marketable, clear, free and unencumbered except as set forth herein, and that Grantor will forever defend the right and title to said property unto Grantee against the claims of all persons whomsoever.

IN WITNESS WHEREOF, Grantor has signed and sealed this Deed the day and year above written.

James C. Hudson, Jr.

Sharon D. Hudson

NO TRANSFER TAX DUE
SARAH P. DeFRIESE
County Register

F 3 4 4 5

IDENTIFICATION REFERENCE.

NOV 15 2 03 PM '88

SARAH P. DeFRIESE
REGISTER
HAMILTON COUNTY
STATE OF TENNESSEE

11/15/88 CONV 1,255,050.00 V
11/15/88 W/DD 8.00 **8.00 B

STATE OF TENNESSEE COUNTY OF HAMILTON

Before me, the undersigned Notary Public of the state and county aforesaid, personally appeared James C. Hudson, Jr. and wife, Sharon D. Hudson

the within named bargainor, with whom I am personally acquainted, or proved to me on the basis of satisfactory evidence, and who acknowledged that they executed the within instrument for the purposes therein contained.

WITNESS my hand, at office, this 15th day of November 19 88

Date of Expiration of Commission: 8-12-89

Robert L Brown
Notary Public (SEAL)

STATE OF _____ COUNTY OF _____

Before me, the undersigned Notary Public of the state and county aforesaid, personally appeared _____, with whom I am personally acquainted, or proved to me on the basis of satisfactory evidence, and who, upon oath, acknowledged himself to be the _____ of the _____, the within named bargainor, a corporation, and that he, as such officer, executed the foregoing instrument for the purpose therein contained, by signing the name of the corporation by himself as such officer.

WITNESS my hand, at office, this _____ day of _____, 19____.

Date of Expiration of Commission: _____

_____
Notary Public (SEAL)

STATE OF TENNESSEE COUNTY OF HAMILTON

The undersigned Grantee hereby swears or affirms that the actual consideration for this transfer, or value of the property transferred, whichever is greater, is $ 1,255,050.00 which amount is equal to or greater than the amount which the property transferred would command at a fair and voluntary sale

L H Kennedy Conner

Signed and sworn to or affirmed before me on this the 15th day of Nov 1988

Date of Expiration of Commission 8-12-89

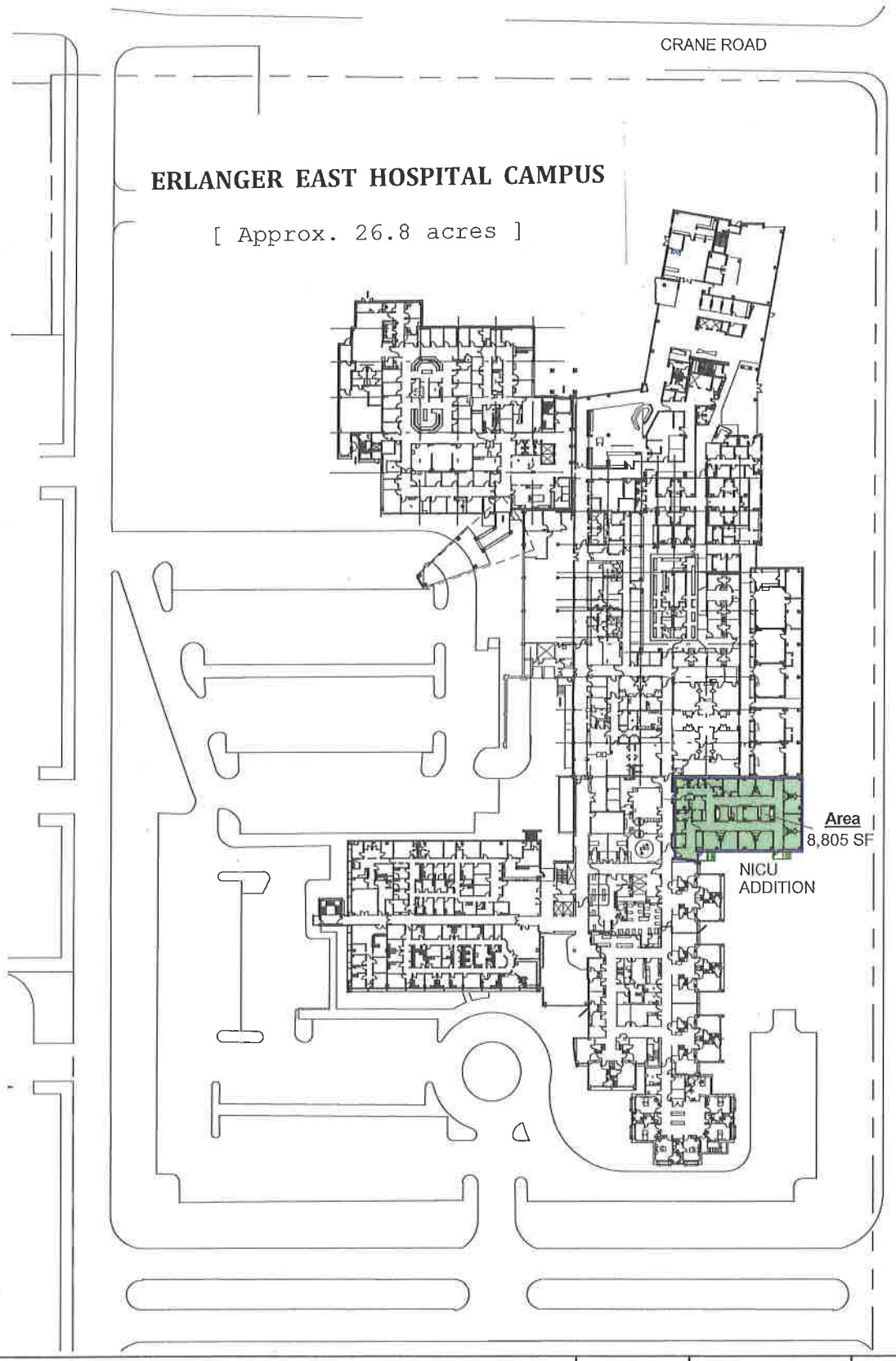
Robert L Brown
Notary Public (SEAL)

Description	Section / Item
Square Footage & Cost Per Square Foot Chart	B-II-A

Square Footage & Cost Per Square Footage Chart

A. - Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	= Proposed Final Square Footage = Renovated	New	Total	== Proposed Final Cost Per SF === Renovated	New	Total
Erlanger East - Level 3 NICU	N / A	0	N / A	2nd Floor -	0	8,805	8,805	0.00	403.38	7,005,221
B. - Unit/Dept. GSF - Sub-Total								0.00	403.38	7,005,221
C. - Mechanical/Electrical GSF					Included	Included				
D. - Circulation/Construction GSF					Included	Included				
E. - Total GSF		0			0	8,805	8,805	0.00	403.38	7,005,221

Description	Section / Item
Erlanger East Hospital - Plot Plan	B-III-A



HKS

HKS, INC.
TWO LIVE OAK CENTER
3445 PEACHTREE ROAD, NE
SUITE 675
ATLANTA, GA 30326

10 BED NICU ADDITION
SITE LOCATION PLAN

HKS PROJECT # 18791.000

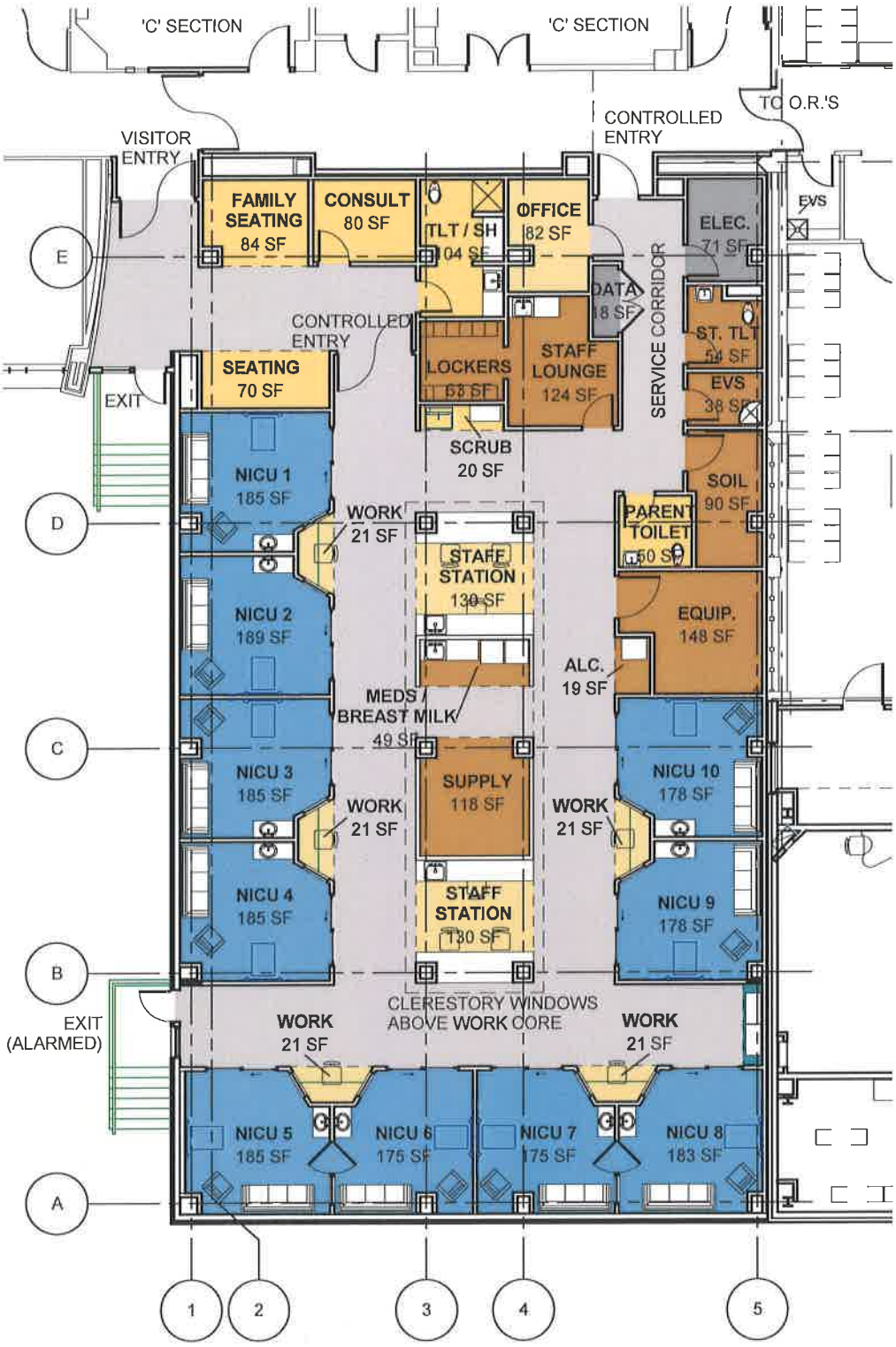
ISSUE: CON

DATE: 04/02/15

SKETCH NO. A-101

REVISION NO. △

Description	Section / Item
Erlanger East Hospital - Floor Plan	B-IV



TOTAL NEW CONSTRUCTION = 8,805 BGSF, Inclusive of Shell Space Below

HKS

HKS, INC.
TWO LIVE OAK CENTER
3445 PEACHTREE ROAD, NE
SUITE 675
ATLANTA, GA 30326

10 BED NICU ADDITION
SCHEMATIC FLOOR PLAN

HKS PROJECT # 18791.000

ISSUE: CON

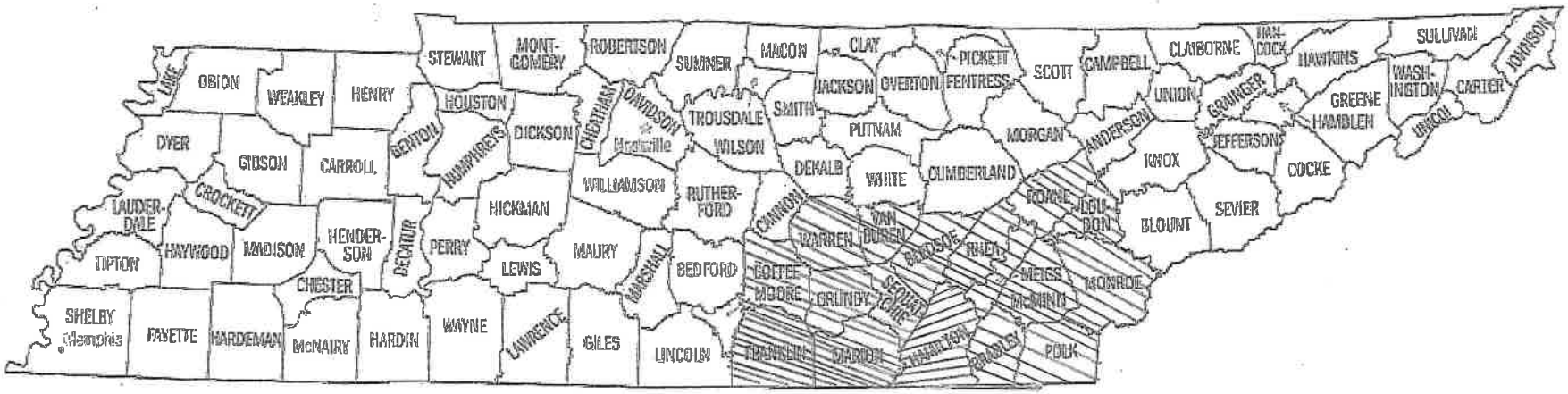
DATE: 04/02/15

SKETCH NO. A-201

REVISION NO.

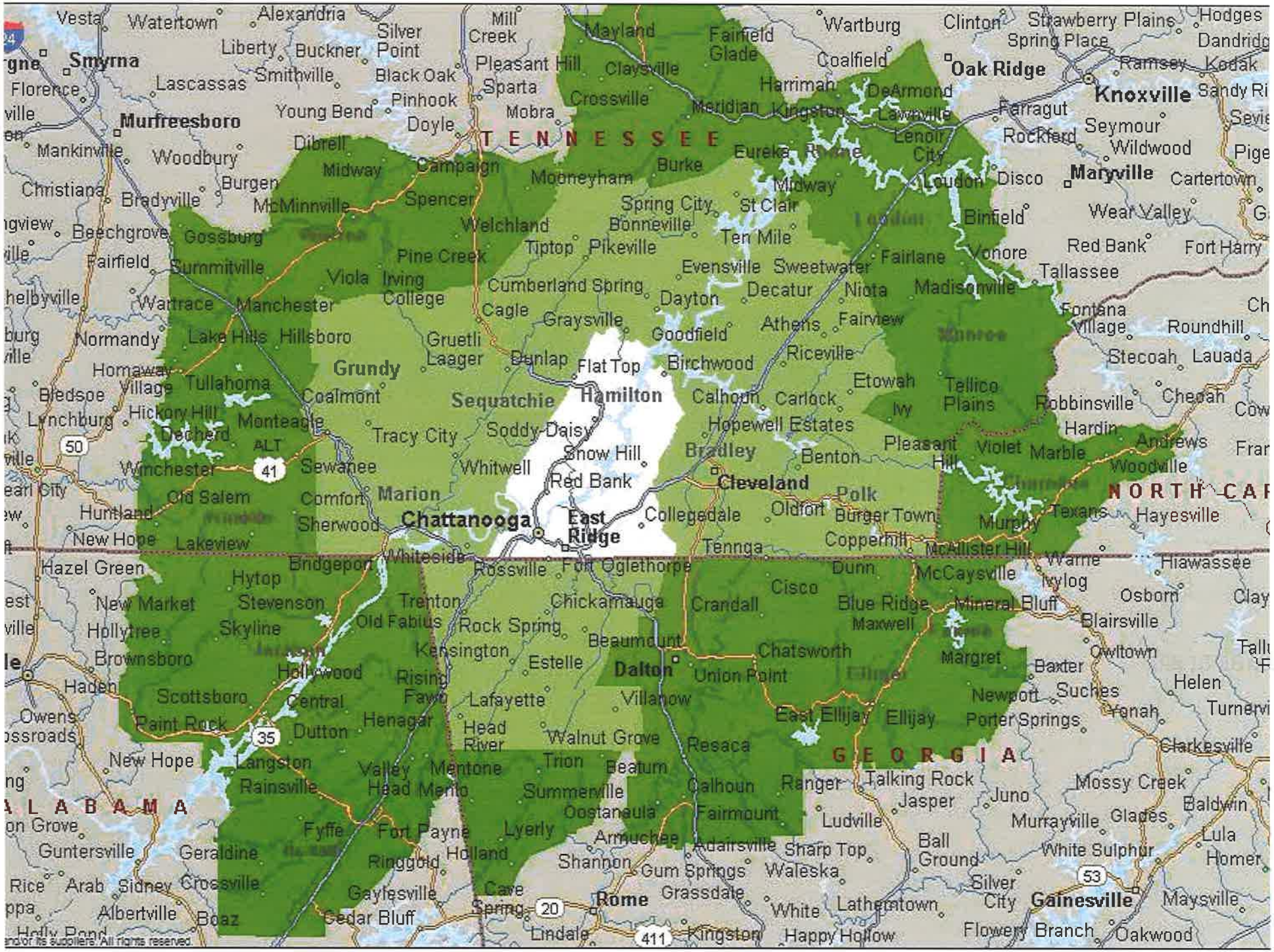
Description	Section / Item
Service Area	C-I-3

County	State	Service Area
Hamilton	TN	PSA
Bledsoe	TN	SSA
Bradley	TN	SSA
Grundy	TN	SSA
Marion	TN	SSA
McMinn	TN	SSA
Meigs	TN	SSA
Polk	TN	SSA
Rhea	TN	SSA
Sequatchie	TN	SSA
Catoosa	GA	SSA
Dade	GA	SSA
Walker	GA	SSA
Dekalb	AL	TSA
Jackson	AL	TSA
Chattooga	GA	TSA
Fannin	GA	TSA
Gilmer	GA	TSA
Gordon	GA	TSA
Murray	GA	TSA
Whitfield	GA	TSA
Cherokee	NC	TSA
Coffee	TN	TSA
Cumberland	TN	TSA
Franklin	TN	TSA
Loudon	TN	TSA
Monroe	TN	TSA
Roane	TN	TSA
Van Buren	TN	TSA
Warren	TN	TSA



Primary Service Area

Secondary & Tertiary Service Area



Description	Section / Item
Architect Letter - Construction Cost	C-II-1

HKS

Dan Luhrs
AIA, NCARB
ASSOCIATE PRINCIPAL & SENIOR VICE PRESIDENT

January 6, 2016

Mr. Joseph M. Winick
Senior Vice President
Planning, Analytics & Business Development
Erlanger Health System
975 East Third Street
Chattanooga, Tennessee 37403

Re: (10) Bed NICU Addition
Erlanger East
HKS Architects, Inc. 18791

Dear Mr. Winick:

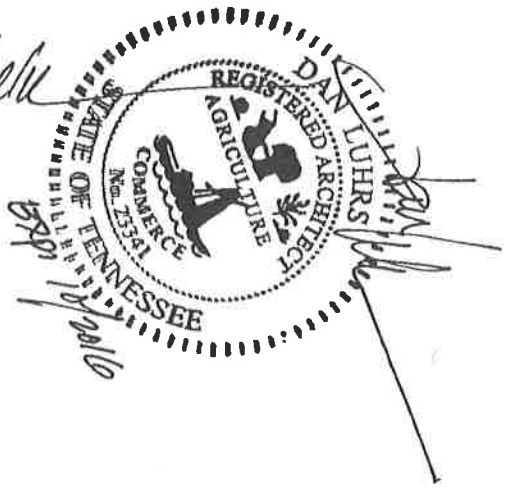
The construction budget indicating $3,551,783, without the planned contingencies, is reasonable, given consideration to the scale of the project and the complexity for this type of construction. Additionally, the projected date for the Initiation of Service of January 2018 includes reasonable time for all activities associated with this project to be completed, based on the CON Initial Decision Date of April 27, 2016.

The design for the addition will meet all known current building codes, TDoH Licensing Standards and will comply with the 2010 Facilities Guidelines Institute standards.

Lastly, the design will incorporate the manufacturer's specifications for preparing this addition to facilitate equipment installation.

Sincerely,

Dan Luhrs



Description	Section / Item
Funding - CFO Letter	C-II-2

erlanger

January 8, 2016

Ms. Melanie Hill, Executive Director
Tennessee Health Services Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: Level III – NICU
Erlanger East Hospital

Dear Ms. Hill,

This letter serves to confirm Erlanger's intent to cover the $ 7,021,555 cost of the Level III NICU at Erlanger East Hospital with funds from operations, subject to CON approval as well as approval of the Chattanooga-Hamilton County Hospital Authority.

Please let me know if you have any questions or need further information. Thank you for your consideration.

Sincerely,

J. Britton Tabor, CPA
Executive V.P. & CFO / Treasurer

Description	Section / Item
Other Expenses - Historical Data Chart	C-II-4
Other Expenses - Projected Data Chart	C-II-4

Historical Data Chart -- Summary Of Other Expenses

	Description	FY 2013	FY 2014	FY 2015
Total -- All Other		**156,440,656**	**166,565,645**	**190,945,905**
Purchased Services		111,584,374	114,459,641	137,413,193
Utilities		9,736,115	10,012,328	9,572,575
Drugs		32,921,513	39,370,552	43,565,706
Insurance and Taxes		2,198,654	2,723,124	394,431
Purchased Services		**111,584,374**	**114,459,641**	**137,413,193**
620142	Restricted Fund Expense	76,633	117,503	208,885
620252	Physician Fees	20,510,257	20,661,564	20,931,912
620302	Consulting	8,018,102	1,421,495	1,089,231
620322	Legal Fees	2,393,527	3,057,657	8,823,824
620332	Audit Fees	194,406	189,312	182,998
620352	Architect & Eng Fees	182,585	360,654	613,919
620492	Time & Mat Contract	3,023,421	4,101,893	4,899,444
620502	Dietary	621,402	685,028	616,065
620522	Unscheduled Maint	4,687,799	5,182,758	4,092,044
620523	CUC Delivery/Vehicle Expense	32,607	17,732	13,351
620532	Advertising	2,555,479	2,490,627	3,074,645
620542	Purchased Services	29,055,253	31,846,157	36,829,150
620562	Purchased Maint	3,220,291	4,115,060	3,668,545
620572	Freight Charges	314,512	293,794	376,663
620573	CUC Penalties	1,425		534
620574	CUC Late Fees	4,971	7,378	4,819
620582	Collection Fees	738,913	904,813	1,258,006
620602	Lab Outside Fees	3,205,690	3,257,673	3,895,713
620622	Computer Services	4,970,519	5,156,385	5,329,474
620682	Micro Maint	74,128	60,533	53,293
620692	Equipment Rental	3,033,690	3,605,722	4,984,163
620792	Contracted Services	18,663,071	20,802,740	29,254,214
620892	Membership & Dues	1,167,871	948,989	1,218,596
620902	Special Classes	27,957	45,251	5,251
620912	Licenses & Fees	1,281,524	1,379,705	1,572,753
620922	Development Costs	176,338	406,179	503,177
620932	Professional Education	1,045,961	1,161,763	1,549,923
620933	CUC Meals & Entertainment	11,491	1,291	2,049
620952	Local Travel	323,282	287,345	330,427
620953	CUC Field Trip Expense	12,657	23,799	28,131
620982	Business Courtesy	44,274	13,444	15,270
621182	Asbestos Expense	128,761	63,639	67,203
621202	Recruiting	670,202	824,569	1,025,697
621272	Resident Education	295,055	295,284	10,154
621532	Public Relations	487,507	271,427	516,360
621972	Patient parking	217,813	213,034	367,196
622002	Med/Prof Housing Expense	115,000	187,444	114
Utilities		**9,736,115**	**10,012,328**	**9,572,575**
640702	Billed Utilities	-461,256	-576,458	-708,356

Historical Data Chart -- Summary Of Other Expenses

640712	Electricity	5,927,593	6,124,308	6,237,145
640722	Gas	1,559,592	1,848,971	1,561,890
640732	Water	1,136,971	1,195,584	1,122,990
640742	Oil	6,450	19,507	27,417
640752	Storm Water Fees	39,551	43,267	34,913
640882	Telephone	1,527,215	1,357,149	1,296,576
Drugs		**32,921,513**	**39,370,552**	**43,565,706**
630403	Drugs	32,921,513	39,370,552	43,565,706
Insurance and Taxes		**2,198,654**	**2,723,124**	**3,194,431**
670847	Self Insurance Expense	952,825	704,755	777,476
670857	Insurance	1,207,188	1,971,569	2,376,846
680878	CUC Taxes - Sales	629	178	340
680880	Gross Receipts Tax	38,012	46,622	39,769

Projected Data Chart -- Summary Of Other Expenses

		Description	YR1	YR2
Total -- All Other			**277,585**	**261,604**
	PURCHASED SERVICES		204,922	215,405
	DRUGS		44,615	46,199
	MARKETING		25,000	0
Purchased Services		**Total Purchased Services**	**204,922**	**215,405**
	620252	Physician Fees	153,224	161,062
	620502	Dietary	4,313	4,533
	620522	Unscheduled Maint	7,367	7,743
	620542	Purchased Services	16,694	17,548
	620572	Freight Charges	4,624	4,861
	620672	Rent/Lease Copier	6,726	7,070
	620932	Professional Education	8,320	8,745
	620952	Local Travel	3,655	3,842
Drugs			**44,615**	**46,199**
	630403	Drugs	44,615	46,199
		Marketing	25,000	0

Description	Section / Item
EHS -- NICU Daily Room Charge List	C-II-6-A
List Of Average Patient Charges	C-II-6-B

EHS – Analysis Of Average Inpatient Charges For CY 2013

	Erlanger Med Ctr	Memorial Hosp	Parkridge Med Ctr	Erlanger East	Memorial Hosp-Hixson	Parkridge East Hosp
Adverse Effects	23,632	24,363	25,768			
Back & Spine	56,372	62,321	77,068		20,302	26,192
Burns	41,854		79,165		19,805	63,991
Cardiac Surgery	121,317	124,382	187,761			18,129
Dermatology	12,638	18,047	22,945			
Electrophysiology / Devices	68,224	64,498	137,067		15,063	22,421
Endocrinology	16,973	20,382	34,172		33,055	106,849
Gastroenterology	20,922	23,279	37,279	7,649	15,515	30,963
General Cardiology	20,092	23,017	33,878		19,865	31,626
General Surgery	56,962	44,511	72,165	44,632	20,564	32,532
Gynecology	30,925	34,881	41,628	22,990	33,317	44,307
Hematology	18,019	25,238	55,193		19,142	27,419
HIV Infection	43,118	36,835	38,690		24,342	38,090
Infectious Diseases	48,905	48,026	78,291		17,866	42,950
Invasive Cardiology	46,838	43,668	89,668		29,658	67,501
Neonatology	57,502			10,439	33,878	84,705
Nephrology	19,648	24,320	35,305	11,355		45,521
Neurology	27,860	25,879	36,859		19,051	31,393
Neurosurgery	69,488	35,049	49,150		22,363	33,884
Obstetrics	11,227	12,221	8,801	7,956	29,527	39,255
Oncology	27,498	35,313	59,406		5,393	13,730
Ophthalmology	19,265	17,105	40,009		23,053	53,594
Oral Surgery	15,522	16,295	20,298		12,855	30,541
Orthopedics	45,866	40,948	51,258	39,291	14,870	23,542
Other	69,279	49,940	104,685	19,106	37,175	49,102
Otolaryngology	27,603	22,553	22,753		52,845	57,632
Plastic Surgery	48,458	33,725	49,094		13,316	34,818
Psychiatry	16,521	16,554	41,849		23,011	79,799
Pulmonary Medicine	70,570	40,588	54,690		19,930	29,693
Rehabilitation			59,765		27,048	45,486
Rheumatology	26,929	28,367	35,702			
Signs & Symptoms	15,456	19,239	30,847		11,344	85,627
Substance Abuse	17,311	20,504	35,410		14,499	34,786
Thoracic Surgery	43,438	55,261	81,953		17,257	32,229
Transplant Surgery	133,754	297,368	#DIV/0!		18,872	61,596
Urology	35,591	37,434	46,512	25,739		
Vascular Diseases	16,605	20,754	28,747		20,161	29,775
Vascular Surgery	67,895	75,014	100,399		13,739	26,520
					48,503	108,824
Total	37,396	40,269	61,289	9,085	25,131	29,292

Source: EHS Planning

9/9/2014

Charge Code	Description	UB Revenue Code	Charge Amount
26100016	NICU Acuity Level I	171	1,155.00
26100024	NICU Acuity Level II	172	2,736.00
26100032	NICU Acuity Level III	173	4,134.00
26100040	NICU Acuity Level IV	174	5,775.00

Description	Section / Item
Erlanger Interim Financial Statements	C-II-10
Erlanger Audited Financial Statements	C-II-10

Consolidated Interim Financial Statements

Quarter Ending September 30, 2015

This financial report is confidential and proprietary information. This document is not a public record until finalized and released by the chief financial officer. The embargo date for the information contained herein is October 19, 2015 at 5P.M. EST. No part of the information contained herein may be released or discussed publicly until this date.

ERLANGER HEALTH SYSTEM
Unaudited Consolidated Balance Sheets as of: September 30, 2015

ASSETS	2016	2015
UNRESTRICTED FUND		
CURRENT:		
Cash and temporary investments	$ 89,196,975	$ 50,723,375
Funds held by trustee - current portion	8,852,073	10,121,996
Patient accounts receivable	397,260,890	332,792,295
Less allowances for patient A/R	(296,732,311)	(254,547,878)
Net patient accounts receivable	100,528,579	78,244,417
Other receivables	31,492,770	32,691,336
Due from third party payors	5,234,783	16,681,569
Inventories	14,260,086	12,830,058
Prepaid expenses	9,203,361	7,138,777
Total current assets	258,768,627	208,431,528
PROPERTY, PLANT, AND EQUIPMENT		
Net property, plant and equipment	148,508,314	148,106,020
LONG-TERM INVESTMENTS	324,862	428,022
OTHER ASSETS:		
Assets whose use is limited	184,180,285	131,953,425
Deferred debt issue cost	848,306	2,036,905
Other assets	1,439,943	1,632,856
Total other assets	186,468,534	135,623,186
DEFERRED OUTFLOWS OF RESOURCES		
Deferred pension adjustments	3,959,346	-
Deferred amounts from debt refunding	615,890	701,828
TOTAL	**$ 598,645,574**	**$ 493,290,583**

LIABILITIES	2016	2015
UNRESTRICTED FUND		
CURRENT:		
Current maturities of long term debt	$ 4,804,418	$ 10,865,628
Accounts payable	60,829,650	39,703,742
Accrued salaries & related liabilities	25,897,437	23,195,516
Due to third party payors	-	1,493,918
Construction fund payable	185,543	61,187
Accrued Interest payable	4,565,890	3,127,456
Total current liabilities	96,282,938	78,447,447
NET PENSION LIABILITY (GASB 67, 68 & FAS 112)	53,835,079	48,886,964
RESERVE FOR OTHER LIABILITIES	18,115,727	23,515,699
DEFERRED INFLOWS OF RESOURCES		
Deferred pension adjustments	318,312	-
Deferred gain from sale-leaseback	3,470,969	3,935,725
LONG - TERM DEBT	211,734,417	159,034,778
FUND BALANCE:		
Unrestricted	194,234,470	163,463,286
Invested in capital assets, net of related debt	15,499,149	11,077,072
Restricted	5,154,514	4,929,612
	214,888,133	179,469,971
TOTAL	**$ 598,645,574**	**$ 493,290,583**

Erlanger Health System

Unaudited Consolidated Statement of Operations

For the quarter ended September 30, 2015 and 2014

	Current Quarter		
	Actual	Budget	Prior Year
Net patient service revenue	$ 182,854,579	$ 173,230,321	$ 156,887,696
Other revenue(expense)	8,209,136	8,022,352	7,514,887
Net operating revenue	191,063,714	181,252,674	164,402,583
Expenses			
Salaries and employee benefits	98,830,526	96,809,576	83,936,316
Supplies	25,103,773	22,474,078	20,518,179
Purchased services	36,950,136	35,947,645	31,169,525
Utilities	2,893,780	2,465,709	2,818,520
Drugs	12,696,565	10,903,402	10,293,649
Depreciation	7,278,070	7,263,432	7,085,216
Insurance & taxes	959,764	933,326	858,551
Total operating expense	184,712,613	176,797,169	156,679,956
Excess rev. over/(under) exp. from operations	6,351,101	4,455,505	7,722,627
NONOPERATING INCOME:			
Gain (Losses) on disposal of assets	79,541	88,611	50,378
Interest Income/Gains (Losses) on Investments	490,426	183,663	225,411
Interest expense	(2,469,962)	(2,806,949)	(2,007,187)
Mark to market on swaps	-	-	686,536
Provisions for income tax	(134,466)	(127,660)	(133,551)
Excess rev. over/(under) expenses	$ 4,316,640	$ 1,793,169	$ 6,544,215
Operating Margin	3.32%	2.46%	4.70%
Total Margin	2.26%	0.99%	3.56%

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY (d/b/a Erlanger Health System and Discretely Presented Component Units)

Audited Combined Financial Statements

Year Ended June 30, 2015

PYA
Certified Public Accountants

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Audited Combined Financial Statements

Years Ended June 30, 2015

PERSHING YOAKLEY & ASSOCIATES, P.C.
One Cherokee Mills, 2220 Sutherland Avenue
Knoxville, TN 37919
p: (865) 673-0844 | f: (865) 673-0173
www.pyapc.com

PYA
Certified Public Accountants

INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees of
Chattanooga-Hamilton County Hospital Authority
(d/b/a Erlanger Health System):

Report on the Combined Financial Statements

We have audited the accompanying combined financial statements of the business-type activities of Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System (the Primary Health System) and its discretely presented component units, as of and for the year ended June 30, 2015, and the related notes to the combined financial statements, which collectively comprise the Primary Health System's basic combined financial statements as listed in the table of contents.

Management's Responsibility for the Combined Financial Statements

Management is responsible for the preparation and fair presentation of these combined financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of combined financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express opinions on these combined financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the combined financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Primary Health System's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness

of significant accounting estimates made by management, as well as evaluating the overall presentation of the combined financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the respective financial position of the business-type activities and the discretely presented component units of the Primary Health System as of June 30, 2015, and the respective changes in financial position and, where applicable, cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

As discussed in Note A to the combined financial statements, during the year ended June 30, 2015, the Primary Health System adopted a newly issued accounting standard that requires retroactive adjustments to amounts previously reported with a cumulative effect adjustment to net position as of June 30, 2014. Our opinion is not modified with respect to this matter.

Other Matters

Required Supplementary Information: Accounting principles generally accepted in the United States of America require that the Management's Discussion and Analysis (shown on pages 3 through 10), the Schedule of Changes in Net Pension Liability and Related Ratios (shown on page 48) and the Schedule of Actuarial Contributions (shown on page 49) be presented to supplement the basic combined financial statements. Such information, although not a part of the basic combined financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic combined financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic combined financial statements, and other knowledge we obtained during our audit of the basic combined financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Pershing Yoakley & Associates PC

Knoxville, Tennessee
September 17, 2015

Management's Discussion and Analysis

MANAGEMENT'S DISCUSSION AND ANALYSIS

The discussion and analysis of Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System's financial performance provides an overview of financial activities for the fiscal year ended June 30, 2015.

Erlanger Health System (the Primary Health System) is the largest healthcare provider in Southeast Tennessee. The Primary Health System maintains a number of very specialized clinical services such as Level I trauma, Level III neonatal, kidney transplantation, a Regional Cancer Unit, a full service children's hospital, and open heart surgery, all of which are primarily serviced by four "Life Force" helicopters and supported by subspecialty physicians (residents, faculty and private attending physicians) located on its campuses.

OVERVIEW OF THE COMBINED FINANCIAL STATEMENTS

The combined financial statements consist of two parts: Management's Discussion and Analysis and the combined financial statements. The combined financial statements also include notes that explain in more detail some of the information in the combined financial statements.

The combined financial statements of the Primary Health System offer short-term and long-term financial information about its activities. The combined statements of net position include all of the Primary Health System's assets and liabilities and provide information about the nature and amounts of investments in resources (assets) and the obligations to the Primary Health System's creditors (liabilities). The assets and liabilities are presented in a classified format, which distinguishes between current and long-term assets and liabilities. It also provides the basis for computing rate of return, evaluating the capital structure of the Primary Health System and assessing the liquidity and financial flexibility of the Primary Health System.

All of the fiscal year's revenues and expenses are accounted for in the combined statements of revenue, expenses, and changes in net position. These statements measure the success of the Primary Health System's operations and can be used to determine whether the Primary Health System has successfully recovered all of its costs through the services provided, as well as its profitability and credit worthiness.

The final required financial statement is the combined statement of cash flows. The primary purpose of this statement is to provide information about the Primary Health System's cash receipts, cash payments and net changes in cash resulting from operating, investing, non-capital financing and financing activities. The statement also provides answers to such questions as where did cash come from, what was cash used for, and what was the change in the cash balance during the reporting period?

The analysis of the combined financial statements of the Primary Health System begins on the next page. One of the most important questions asked about the Primary Health System's finances is "Is the financial condition of the Primary Health System as a whole better or worse as a result of the fiscal year's activities?" The combined statements of net position and the combined statements of revenue, expenses and changes in net position report information about the Primary Health System's activities in a way that will help answer this question. These two statements report the net position of the Primary Health System and changes in the net position. One can think of the Primary Health System's net position – the difference between assets and liabilities – as one way to measure financial health or financial position. Over time, increases or decreases in the Primary Health System's net position is one indicator of whether its financial health is improving or deteriorating. However, one will need to consider other non-financial factors such as changes in economic conditions, regulations and new or changed government legislation.

REPORTING ENTITY

The Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System (the Primary Health System) was created by a private act passed by the General Assembly of the State of Tennessee on March 11, 1976, and adopted by a majority of the qualified voters of Hamilton County, Tennessee on August 5, 1976. The Primary Health System is considered the primary governmental unit for financial reporting purposes. As required by generally accepted accounting principles, these financial statements present the Primary Health System and its component units. The component units discussed below are included in the Primary Health System's reporting entity because of the significance of their operational, financial or other relationships with the Primary Health System.

ContinuCare HealthServices, Inc., Cyberknife of Chattanooga, LLC (Cyberknife), UT-Erlanger Medical Group, Inc. (the Medical Group) and Erlanger Health Plan Trust are legally separate organizations for which the Primary Health System is either financially accountable or owns a majority interest. Accordingly, these organizations represent component units of the Primary Health System. The financial statements of Erlanger Health Plan Trust are blended with the financial statements of the Primary Health System, as the Board of Erlanger Health Plan Trust is substantially the same as that of the Primary Health System and the Primary Health System has operational responsibility.

During fiscal year 2011, Cyberknife was capitalized by contributions from the Primary Health System and certain other minority partners. Cyberknife provides radiation therapy services, specifically robotic stereotactic radiosurgical services through the use of a Cyberknife stereotactic radiosurgery system on the Primary Health System's campus. At June 30, 2015, and 2014, the Primary Health System owned 51% of Cyberknife's outstanding membership units. The Medical Group was formed on June 30, 2011 and will provide professional healthcare and

related services to the public through its employed and contracted licensed physicians and other supporting healthcare providers. The Medical Group has no members; however, the Primary Health System may access the Medical Group's services. The Medical Group is currently not active.

KEY FINANCIAL INDICATORS

The following key financial indicators are for Erlanger Health System as a whole. They are inclusive of the Primary Health System, ContinuCare HealthServices, Inc., and the 51% controlling share of Cyberknife of Chattanooga, LLC.

- Excess revenues over expenses for Erlanger Health System for fiscal year 2015 is $37 million compared to excess of revenue over expenses of $11 million for fiscal year 2014.

- Excess revenues over expenses from operations for Erlanger Health System for fiscal year 2015 is $48 million compared to excess of revenue over expenses of $18 million for fiscal year 2014.

- Total cash and investment reserves at June 30, 2015 are $102 million (excluding $103 million in capital investment funds and $84 million of funds held by Trustees or restricted by donors or others).

- Net days in accounts receivable for Erlanger Health System (utilizing a three month rolling average of net revenue) is 47 days at June 30, 2015 compared to 50 days at June 30, 2014.

- For fiscal year 2015, Erlanger Health System recognized $18.8 million in public hospital supplemental payments from the State of Tennessee compared to $19.6 million in fiscal year 2014.

- For fiscal year 2015, Erlanger Health System recognized $17.4 million in essential access payments from the State of Tennessee compare to $12.8 million in fiscal year 2014 compared to $12.8 million in fiscal year 2014.

- For both fiscal year 2015 and 2014, Erlanger Health System did not recognize disproportionate share payments from the State of Tennessee.

- For fiscal year 2015, Erlanger Health System recognized $1.1 million in trauma fund payments from the State of Tennessee compared to $0.9 million in fiscal year 2014.

The required bond covenant ratios for fiscal year 2015 compared to bond requirements are as follows:

			Bond Insurer Requirements	
	June 30, 2015	Master Trust Indenture	14 Series	04 Series
Debt service coverage ratio	5.41	1.10	1.35	1.35
Current ratio	2.67	N/A	1.50	1.50
Days cash on hand	104	N/A	65 days	65 days
Indebtedness ratio	52%	N/A	65%	65%

The trust indentures and related documents underlying the bonds contain certain covenants and restrictions. For fiscal year 2015, Erlanger Health System met all required debt covenants.

NET POSITION

Erlanger Health System's net position for the combined Primary Health System and Aggregate Discretely Presented Component Units increased by approximately $37.6 million in fiscal year 2015. Our analysis focuses on the net position (Table 1) and changes in net position (Table 2) of the Primary Health System's operating activities. Discussion focuses on the Primary Health System and its blended component units.

Net position for the Primary Health System increased from $195 million as of June 30, 2014 to $211 million as of June 30, 2015. The current ratio (current assets divided by current liabilities) increased from 2.52 in 2014 to 2.67 in 2015 for the Primary Health System.

Table 1- Net Position (in Millions)

	June 30, 2015		June 30, 2014	
	Primary Health System	Discretely Presented Component Units	Primary Health System	Discretely Presented Component Units
Current and other assets	$ 442	$ 13	$ 332	$ 12
Capital assets	142	8	149	9
Total assets	585	21	480	21
Deferred ouflows of resources	6	-	1	-
	$ 590	$ 21	$ 481	$ 21

Year Ended June 30, 2015

	June 30, 2015		*June 30, 2014*	
	Primary Health System	***Discretely Presented Component Units***	***Primary Health System***	***Discretely Presented Component Units***
Long-term debt outstanding	**$ 213**	**$ -**	$ 159	$ 4
Other liabilities	**163**	**6**	123	3
Total liabilities	**376**	**6**	282	7
Deferred inflows of resources	**4**	**-**	4	-
	$ 380	**$ 6**	$ 286	$ 7
Net position				
Net investment in capital assets	**$ 2**	**$ 5**	$ 1	$ 5
Restricted, expendable	**3**	**-**	2	-
Unrestricted	**206**	**10**	191	9
Total net position	**$ 210**	**$ 15**	$ 194	$ 14

Days in cash increased from 88 days as of June 30, 2014 to 104 days as of June 30, 2015 for the Primary Health System resulting from increased operating margins.

Days in net accounts receivable for the Primary Health System were 51 days as of June 30, 2015 and 2014.

Capital assets for the Primary Health System were $142 million as of June 30, 2015. Additions for fiscal year 2015 totaled $18 million while $16 million of assets were retired or sold. Depreciation expense was $25 million for the Primary Health System. Retirement of assets reduced accumulated depreciation by $11 million in fiscal year 2015. Construction in progress was $11 million as of June 30, 2015. Included in construction in progress is the Erlanger East expansion totaling $5.7 million.

Long-term debt outstanding amounted to $213 million as of June 30, 2015 compared to $159 million as of June 30, 2014. The increase in long-term debt reflects $71 million of new money included in the Series 2014 Bonds.

Other liabilities for the Primary Health System were $163 million as of June 30, 2015 compared to $123 million as of June 30, 2014, due in part to the recognition of the pension liability required by a new accounting standard.

CHANGES IN NET POSITION

The focus for Erlanger Health System's management team during fiscal year 2015 was to increase the Primary Health System's volumes in a number of key product lines in a flat market, improve relationships with stakeholders, and improve operating efficiencies.

Table 2- Changes in Net Position (in Millions)

	June 30, 2015		*June 30, 2014*	
	Primary Health System	***Discretely Presented Component Units***	***Primary Health System***	***Discretely Presented Component Units***
Net patient revenue	$ 670	$ 11	$ 571	$ 11
Other revenue	16	18	21	17
Total revenue	686	29	592	28
Expenses:				
Salaries	333	14	305	14
Supplies and other expenses	140	10	126	10
Purchased services	141	3	117	3
Depreciation and amortization	25	1	26	1
Total expenses	638	28	574	28
Operating income revenues in excess of (less than) expenses	47	1	18	1
Nonoperating gains	2	-	2	-
Interest expense and other	(12)	-	(9)	-
Operating/capital contributions	0	-	1	-
Change in net position	$ 38	$ 1	$ 12	$ 1

Net patient service revenue for the Primary Health System increased from $571 million in fiscal year 2014 to $670 million in fiscal year 2015. Admissions for fiscal year 2015 were 33,340 compared to 30,394 for fiscal year 2014, a 9.7% increase. Observation days decreased from 8,398 for fiscal year 2014 to 7,836 for fiscal year 2015, or by 6.7%. Air ambulance flights increased from 1,870 flights for fiscal 2014 to 1,994 flights for fiscal year 2015, or by 6.6%. Medicare case mix index was 1.88 for fiscal years 2014 and 2015. Total surgical inpatients increased from 9,198 for fiscal year 2014 to 9,856 for fiscal 2015, or by 7.2%. Total surgical outpatients for fiscal year 2015 increased by 4.0% over the prior year. Total emergency room visits were 150,851 for fiscal year 2015, a 14.3 % increase over fiscal year 2014.

Salaries for the Primary Health System increased from $305 million in fiscal year 2014 to $333 million in fiscal year 2015. Staffing was in concert with the increased volumes. Paid FTE's per adjusted occupied bed decreased from 5.1 in fiscal year 2014 to 4.8 in fiscal year 2015, however, salary cost for fiscal year 2015 per hour increased by 8.6% over the prior year. A 2% raise for full time employees (excluding bedside nurses) was implemented in January 2015 and a 2.7% market adjustment for bedside nurses was implemented in July 2014. The post-retirement benefits were discontinued in January 2015.

Supplies and other expenses increased from $126 million for fiscal year 2014 to $140 million in fiscal year 2015. Supplies and drug costs trended with the volume increases. Supplies and drugs per adjusted admission for the Primary Health System increased from $1,555 in fiscal year 2014 to $1,573 in fiscal year 2015.

Purchased Services increased from $117 million in fiscal year 2014 to $141 million in fiscal year 2015 due in part to an increase in contracted hospitalist fees resulting from increased volumes.

Depreciation and amortization expense decreased from $26 million in fiscal year 2014 to $25 million in fiscal year 2015 based on the capital spending plan.

Interest expense, including gain (or loss) on mark-to-market of interest rate swaps in 2014, increased from $9 million in fiscal year 2014 to $12 million in fiscal year 2015. The Series 2014 Bonds issued in December 2014 resulted in $71 million in additional debt. The interest rate swaps agreements were terminated in fiscal year 2015.

OUTLOOK

The State of Tennessee continues to review the TennCare program (the State's Medicaid program). For fiscal years 2012 and 2013, the State passed a Hospital Coverage Fee to offset shortfalls in the State's budget for TennCare. The fee remained intact and TennCare rates were stable in fiscal year 2014 and 2015. There could be possible TennCare rate changes in fiscal year 2016 as a result of rate variation initiatives. Out-of-state Medicaid and TennCare changes would affect the Primary Health System's bottom line with TennCare and Medicaid patients representing approximately 23% of the payer mix. Self-pay patients represent approximately 8% of the charge utilization. Healthcare reform and future changes in Medicare regulations could also have an adverse effect on the Primary Health System's future operations since Medicare represents approximately 33% of the payer mix.

During fiscal year 2014, the Primary Health was added as a participant to the Public Hospital Supplemental Payment Pool for public hospitals in Tennessee through a collaborative effort with local Mayors, State Senators and Representatives, Hamilton County Medical Society, Board members, physicians and hospital leadership. The inclusion of the Primary Health System in the

pool netted $19.6 million of additional federal funding for fiscal year 2014 and $18.8 million for fiscal year 2015. The Primary Health System will receive this funding annually as long as the current TennCare waiver is intact.

The Primary Health System recognized Essential Access payments totaling $17.4 million from the State of Tennessee for fiscal year 2015, an increase of $4.6 million from fiscal year 2014. Disproportionate share payments were not approved by Federal government for fiscal year 2014 and funds received during 2015 have not been recognized until eligibility is determined. Additionally, the Primary Health System recognized trauma funding of $1.1 million in fiscal year 2015 compared to $0.9 million in fiscal year. Payments from the State of Tennessee for the fiscal year 2016 are expected to be consistent with the fiscal year 2015. Due to the 1966 Hamilton County Sales Tax Agreement expiring in May 2011, the Hamilton County appropriations to the Primary Health System have been reduced from $3 million to $1.5 million.

The focus of Erlanger Health System's CEO and leadership team for fiscal year 2015 has been top-line, sustainable growth, cost containment and strengthened physician relations. The strategic plans put in place this fiscal year have yielded strong positive results and enabled investment in Erlanger and the community. The health system has infused $71 million from bond sales into major growth initiatives.

Audited Combined Financial Statements

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statements of Net Position

	June 30, 2015	
	Primary Health System	*Discretely Presented Component Units*
ASSETS		
CURRENT ASSETS:		
Cash and cash equivalents	$ 92,642,502	$ 1,072,363
Temporary investments	3,258,275	5,637,906
Patient accounts receivable, net	93,787,459	2,040,568
Estimated amounts due from third party payers	5,399,871	-
Due from other governments	130,037	409,825
Inventories	12,991,042	1,299,621
Receivable from Hutcheson Medical Center	20,000,000	-
Other current assets	11,832,273	1,563,932
TOTAL CURRENT ASSETS	240,041,459	12,024,215
NET PROPERTY, PLANT AND EQUIPMENT	142,126,358	8,459,744
LONG-TERM INVESTMENTS, for working capital	324,862	-
ASSETS LIMITED AS TO USE	186,519,439	-
OTHER ASSETS:		
Prepaid bond insurance	890,721	-
Equity in discretely presented component units	14,478,062	-
Other assets	189,079	557,145
TOTAL OTHER ASSETS	15,557,862	557,145
TOTAL ASSETS	584,569,980	21,041,104
DEFERRED OUTFLOWS OF RESOURCES		
Deferred pension adjustments	3,959,346	-
Deferred amounts from debt refunding	1,724,071	-
TOTAL DEFERRED OUTFLOWS OF RESOURCES	5,683,417	-
COMBINED ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 590,253,397	$ 21,041,104

See notes to combined financial statements.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statements of Net Position - Continued

	June 30, 2015	
	Primary Health System	***Discretely Presented Component Units***
LIABILITIES		
CURRENT LIABILITIES:		
Accounts payable and accrued expenses	$ 52,923,265	$ 1,361,173
Accrued salaries and related liabilities	25,723,976	1,099,831
Due to other governments	409,825	130,037
Current portion of long-term debt and capital lease obligations	4,782,194	3,036,295
Other current liabilities	7,456,250	178,113
TOTAL CURRENT LIABILITIES	91,295,510	5,805,449
LONG-TERM DEBT AND CAPITAL LEASE OBLIGATIONS	213,102,723	110,221
NET PENSION LIABILITY	51,857,463	-
OTHER LONG-TERM LIABILITIES	19,496,243	-
TOTAL LIABILITIES	375,751,939	5,915,670
DEFERRED INFLOWS OF RESOURCES		
Deferred pension adjustments	318,312	-
Deferred gain from sale-leaseback	3,470,969	-
TOTAL DEFERRED INFLOWS OF RESOURCES	3,789,281	-
NET POSITION:		
Unrestricted	205,862,075	9,755,724
Net investment in capital assets	1,838,341	5,369,710
Restricted expendable:		
Health plan trust	1,623,416	-
Donor restricted	1,388,345	-
TOTAL NET POSITION	210,712,177	15,125,434
COMBINED LIABILITES, DEFERRED OUTFLOWS OF RESOURCES AND NET POSITION	$ 590,253,397	$ 21,041,104

See notes to combined financial statements.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statements of Changes in Net Position

	Year Ended June 30, 2015	
	Primary Health System	*Discretely Presented Component Units*
OPERATING REVENUE:		
Charges for services:		
Net patient service revenue	$ 669,863,550	$ 11,263,001
Other revenue	15,712,983	18,208,040
TOTAL OPERATING REVENUE	685,576,533	29,471,041
OPERATING EXPENSES:		
Salaries, wages and benefits	332,652,156	14,063,605
Supplies and other expenses	136,259,730	10,499,399
Purchased services	140,782,277	2,516,607
Insurance and taxes	3,479,089	352,441
Depreciation	25,125,088	1,148,854
TOTAL OPERATING EXPENSES	638,298,340	28,580,906
OPERATING INCOME	47,278,193	890,135
NONOPERATING REVENUE (EXPENSES):		
Gain on disposal of assets	311,556	185,913
Interest and investment income, net of fees	534,193	(26,043)
Net gain from discretely presented component units	353,793	-
Interest expense	(11,828,171)	(154,532)
Provision for income taxes	-	(407,086)
Change in mark-to-market of interest rate swaps	693,533	-
NET NONOPERATING REVENUE (EXPENSES)	(9,935,096)	(401,748)
INCOME BEFORE CONTRIBUTIONS	37,343,097	488,387
Operating distribtuions	(25,142)	-
Capital contributions	301,429	-
CHANGE IN NET POSITION	37,619,384	488,387
NET POSITION AT BEGINNING OF YEAR, as previously reported	194,553,424	14,637,047
CUMULATIVE EFFECT OF CHANGE IN ACCOUNTING PRINCIPLE	(21,460,631)	-
NET POSITION AT BEGINNING OF YEAR	173,092,793	14,637,047
NET POSITION AT END OF YEAR	$ 210,712,177	$ 29,762,481

See notes to combined financial statements.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statement of Cash Flows

Primary Health System	*Year Ended June 30 2015*
CASH FLOWS FROM OPERATING ACTIVITIES:	
Receipts from third-party payers and patients	$ 663,337,934
Payments to vendors and others for supplies, purchased services, and other expenses	(268,727,175)
Payments to and on behalf of employees	(321,733,330)
Other receipts	16,154,086
NET CASH PROVIDED BY OPERATING ACTIVITIES	89,031,515
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES:	
Contributions	(25,142)
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:	
Acquisition and construction of capital assets, net	(23,837,648)
Proceeds from sale of assets	4,978,206
Principal paid on bonds, capital lease obligations and other	(15,492,190)
Proceeds from issuance of long-term debt	171,465,880
Payments to defease bonds	(109,805,916)
Interest payments on long-term debt	(9,507,644)
Swap termination payment	(3,289,113)
Capital contributions	301,429
NET CASH PROVIDED BY CAPITAL AND RELATED FINANCING ACTIVITIES	14,813,004
CASH FLOWS FROM INVESTING ACTIVITIES:	
Interest, dividends, and net realized gains (losses) on investments	534,193
Change in temporary and long-term investments for working capital	(1,872,133)
Payments received on note receivable	550,000
Net cash transferred to assets limited as to use	(54,590,999)
NET CASH USED IN INVESTING ACTIVITIES	(55,378,939)
INCREASE IN CASH AND CASH EQUIVALENTS	48,440,438
CASH AND CASH EQUIVALENTS AT BEGINNING OF YEAR	44,202,064
CASH AND CASH EQUIVALENTS AT END OF YEAR	$ 92,642,502

See notes to combined financial statements.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statement of Cash Flows - Continued

Primary Health System	*Year Ended June 30 2015*
RECONCILIATION OF OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES:	
Operating income	**$ 47,278,193**
Adjustments to reconcile operating income to net cash provided by operating activities:	
Depreciation	**25,125,088**
Changes in assets and liabilities:	
Patient accounts receivable, net	**(14,358,498)**
Estimated amounts due from third party payers, net	**6,009,092**
Inventories and other assets	**1,126,630**
Accounts payable and accrued expenses	**10,975,005**
Accrued salaries and related liabilities	**10,918,826**
Other current and long-term liabilities	**1,957,179**
NET CASH PROVIDED BY OPERATING ACTIVITIES	**$ 89,031,515**

See notes to combined financial statements.

NOTE A--SIGNIFICANT ACCOUNTING POLICIES

Reporting Entity: The Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System (the Primary Health System) was created by a private act passed by the General Assembly of the State of Tennessee on March 11, 1976, and adopted by a majority of the qualified voters of Hamilton County, Tennessee on August 5, 1976. The Chattanooga-Hamilton County Hospital Authority consists of the Primary Health System and its aggregate discretely presented component units as disclosed below.

The Primary Health System provides comprehensive healthcare services throughout Hamilton and Bledsoe counties, as well as outlying areas in southeastern Tennessee and north Georgia. These services are provided primarily through the hospital and other facilities located on the Baroness campus of Erlanger Medical Center. The Primary Health System also operates other hospitals and clinics throughout the area. The Primary Health System is considered the primary governmental unit for financial reporting purposes. As required by accounting principles generally accepted in the United States of America, these combined financial statements present the Primary Health System and its component units. The component units discussed below are included in the Primary Health System's reporting entity because of the significance of their operational or financial relationships with the Primary Health System.

The primary mission of the Primary Health System and its component units is to provide healthcare services to the citizens of Chattanooga, Hamilton County and the surrounding area. Only those activities directly associated with this purpose are considered to be operating activities. Other activities that result in gains or losses unrelated to the Primary Health System's primary mission are considered to be nonoperating.

Erlanger Health Plan Trust, ContinuCare HealthServices, Inc., Cyberknife of Chattanooga, LLC, and UT-Erlanger Medical Group, Inc. are legally separate organizations which the Primary Health System has determined are component units of the Primary Health System.

Blended Component Units: The financial statements of Erlanger Health Plan Trust include assets limited as to use totaling $1,623,416 as of June 30, 2015 and net investment loss totaling $3,617 for the year ended June 30, 2015 that are blended in the combined financial statements of the Primary Health System. The board of the Erlanger Health Plan Trust is substantially the same as that of the Primary Health System and the Primary Health System has operational responsibility.

Discretely Presented Component Units: The discretely presented component units' column in the combined financial statements includes the financial data of the Primary Health System's other component units. They are reported in a separate column to emphasize that they are legally

separate from the Primary Health System. See the combined, condensed financial information in Note Q.

1. ContinuCare HealthServices, Inc. and subsidiary (ContinuCare) provide health and supportive services to individuals in their homes in the Hamilton County and north Georgia areas. ContinuCare also provides retail pharmacy goods and services at four locations in Hamilton County. The Primary Health System owns 100% of the stock of ContinuCare. Separately audited financial statements for ContinuCare HealthServices, Inc. may be obtained by mailing a request to 1501 Riverside Drive, Suite 140, Chattanooga, Tennessee 37406.

2. Cyberknife of Chattanooga, LLC (Cyberknife) provides radiation therapy services, specifically robotic stereotactic radiosurgical services, through the use of a cyberknife stereotactic radiosurgery system on the Primary Health System's campus. The Primary Health System owns 51% of Cyberknife's outstanding membership units and Cyberknife is fiscally dependent on the Primary Health System.

   A condition of admission as a Member of Cyberknife, is to deliver limited guaranties, guaranteeing pro-rata repayment of indebtedness of Cyberknife incurred to finance its equipment costs and its working capital needs. As of June 30, 2015, total debt outstanding was $3,092,057 with payments due through 2017. Management believes that the Primary Health System will not be required to make any payments related to the guarantee of this indebtedness.

3. UT-Erlanger Medical Group, Inc. (the Medical Group) was formed on June 30, 2011 and will provide professional healthcare and related services to the public through employed and contracted licensed physicians and other supporting healthcare providers. The Medical Group has no members; however, the Primary Health System may access the Medical Group's services. The Primary Health System is not entitled to any potential earnings of the Medical Group except for compensation for services rendered to the Medical group on its behalf. However, based upon the significance of the Medical Group's potential operation to the Primary Health System, management believes its exclusion would be misleading and as such, includes the Medical Group as a component unit. The Medical Group is currently not active.

Erlanger Health System Foundations (the Foundation): The Foundation assists the Primary Health System to promote and develop charitable and educational opportunities as they relate to healthcare services provided by the Primary Health System. The Primary Health System is not financially accountable for the Foundation and as a result, the Foundation has not been included in the combined financial statements.

Contributions from the Foundation totaling approximately $32,000 for the year ended June 30, 2015 were recognized as contribution revenue by the Primary Health System. The Primary Health System provided support to the Foundation of $594,000 in 2015.

Use of Estimates: The preparation of the combined financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities as of the date of the combined financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

Enterprise Fund Accounting: The Primary Health System and its blended component units utilize the enterprise fund method of accounting whereby revenue and expenses are recognized on the accrual basis using the economic resources measurement focus.

Recently Issued or Effective Accounting Pronouncements: In June 2012, the Governmental Accounting Standards Board (GASB) issued Statement No. 68, *Accounting and Financial Reporting for Pensions*. Statement No. 68 provides guidance for improved accounting and financial reporting by state and local government entities related to pensions. It also replaces the requirements of GASB Statement No. 27 and Statement No. 50, as they relate to pensions that are provided through pension plans administered as trusts or equivalent arrangements that meet certain criteria. Additionally, the GASB issued Statement No. 71, *Pension Transition for Contributions Made Subsequent to the Measurement Date*, which is effective concurrent with Statement No. 68. Among other requirements, the Primary Health System recorded a net pension liability that is based on fiduciary plan net position rather than on plan funding. The Primary Health System adopted these Statements in 2015 and a cumulative effect adjustment has been recorded as a restatement of net assets as of June 30, 2014 in the combined financial statements.

In February 2015, the GASB issued Statement No. 72, *Fair Value Measurement and Application*. Statement No. 72 defines fair value and describes how fair value should be measured, what assets and liabilities should be measured at fair value, and what information about fair value should be disclosed in the notes to the financial statements. This statement will become effective in fiscal 2016 and management does not expect any significant impact on the combined financial statements other than additional disclosures.

Net Patient Service Revenue/Receivables: Net patient service revenue is reported on the accrual basis in the period in which services are provided at rates which reflect the amount expected to be collected. Net patient service revenue includes amounts estimated by management to be reimbursable by third-party payer programs under payment formulas in effect. Net patient

revenue also includes an estimated provision for bad debts based upon management's evaluation of collectability based upon the age of the receivables and other criteria, such as payer classification and management's assumptions about conditions it expects to exist and courses of action it expects to take. The Primary Health System's policies do not require collateral or other security for accounts receivable, although the Primary Health System routinely accepts assignment or is otherwise entitled to receive patient benefits payable under health insurance programs, plans or policies. Supplemental payments from the State of Tennessee are recognized when determinable (see Note B).

Charity Care: The Primary Health System accepts patients regardless of their ability to pay. A patient is classified as a charity patient by reference to certain policies established by the County Auditor with regard to the Hamilton County indigent program or by the Primary Health System for other patients. Essentially, these policies define charity services as those services for which minimal payment is anticipated. In assessing a patient's inability to pay, the County and the Primary Health System utilize the generally recognized poverty income levels, but also include certain cases where incurred charges are significant when compared to the income of the patient. These charges are not included in net patient service revenue.

Cash Equivalents: The Primary Health System considers all highly liquid investments with maturities of three months or less when purchased, excluding amounts whose use is limited by board designation, held by trustees under indenture agreement, or otherwise restricted as to use, to be cash equivalents.

Inventories: Inventories consist principally of medical and surgical supplies, general store supplies, and pharmacy items and are stated at lower of cost (first-in, first-out) or fair market value.

Investments: The Primary Health System's investments (including assets limited as to use) are reported at fair market value based on quoted market prices. Assets limited as to use include funds designated by the Board, funds held by trustees under trust indentures, and funds restricted by donors or grantors for specific purposes. The Primary Health System considers those investments with maturities of more than three months when purchased, maturing in more than one year and whose use is not limited by board designation, held by trustees under indenture agreement, or otherwise restricted as to use, to be long-term investments.

Temporary Investments: The Primary Health System considers all highly liquid investments with maturities of more than three months when purchased and maturing in less than one year, excluding amounts whose use is limited by board designation, held by trustees under indenture agreement, or otherwise restricted as to use, to be temporary investments.

Net Property, Plant and Equipment: Property, plant and equipment is recorded on the basis of cost. Donated assets are recorded at their fair market value at the date of donation. Leases that are substantially installment purchases of property are recorded as assets and amortized over their estimated useful lives ranging from three to thirty years; related amortization is included in depreciation expense. Depreciation expense is computed over estimated service lives of the respective classes of assets using the straight-line method. The Primary Health System has established a capitalization threshold for property, plant and equipment of $2,500 except for computer equipment, which has a threshold of $1,000. Interest expense and interest income on borrowed funds related to construction projects are capitalized during the construction period, if material. Costs of maintenance and repairs are charged to expense as incurred.

The Primary Health System reviews the carrying value of capital assets if facts and circumstances indicate that recoverability may be impaired. A capital asset is considered impaired when its service utility has declined significantly and unexpectedly. The Primary Health System did not experience any prominent events or changes in circumstances affecting capital assets which would require determination as to whether impairment of a capital asset has occurred during the year ended June 30, 2015.

Prepaid Bond Insurance: Financing costs related to insurance associated with bond issues are being amortized over the terms of the respective debt issues by the effective interest method.

Compensated Absences: The Primary Health System recognizes an expense and accrues a liability for employees' paid annual leave and short-term disability in the period in which the employees' right to such compensated absences is earned. Liabilities expected to be paid within one year are included as accrued salaries and related liabilities in the accompanying combined statements of net position.

Derivative Instruments: The Primary Health System records all derivatives as assets or liabilities on the combined statements of net position at estimated fair value and includes credit value adjustments. The Primary Health System's derivative holdings consisted of interest rate swap agreements. Since these derivatives have not been determined to be effective, the gain or loss resulting from changes in the fair value of the derivatives is recognized in the accompanying combined statement of revenue, expenses and changes in net position. The Primary Health System's objectives in using derivatives are to take advantage of the differences between taxable and tax-exempt debt, and manage exposure to interest rate risks associated with various debt instruments (see Note N).

Pensions: Pension amounts (net pension liability, deferred outflows of resources and deferred inflows of resources related to pensions, and pension expense, fiduciary net position of the Primary Health System's pension plan and additions to or deductions from the plan's fiduciary

net position) have been determined on the same basis as they are reported by the Primary Health System. For this purpose, benefit payments are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value

Income Taxes: The Primary Health System is exempt from income taxes under Section 501(a) as an organization described in Section 501(c)(3) of the Internal Revenue Code (IRC). In addition, it qualifies for exemption from federal income taxes pursuant to IRC Section 115 as an instrumentality of the State of Tennessee. Therefore, no provision for income taxes has been recognized in the accompanying combined financial statements for the Primary Health System.

As a for-profit entity, ContinuCare is subject to state and federal income taxes. ContinuCare HealthServices, Inc. and its subsidiary file consolidated federal income tax returns separately from the Primary Health System. At June 30, 2015, ContinuCare had no significant uncertain tax positions. Tax returns for the years ended June 30, 2010 through 2014 are subject to examination by taxing authorities.

As a limited liability corporation, Cyberknife, is subject to State of Tennessee income taxes. At June 30, 2015 Cyberknife had no significant uncertain tax positions. Tax returns for the years ended June 30, 2010 through 2014 are subject to examination by taxing authorities.

Contributed Resources: Resources restricted by donors for specific operating purposes are held as restricted funds and are recognized as operating or capital contributions in the accompanying combined financial statements. When expended for the intended purpose, they are reported as operating distributions and are recognized as other operating revenue. When an expense is incurred for purposes for which both restricted and unrestricted resources are available, restricted resources are used first. Contributed resources consist of amounts restricted by donors for specific purposes. Fundraising expenses are netted against contributions recognized.

Net Position: The net position of the Primary Health System is classified into three components. *Net investment in capital assets* consists of capital and other assets net of accumulated depreciation and reduced by the current balances of any outstanding borrowings used to finance the purchase or construction of those assets. The *restricted expendable* net position consists of assets that must be used for a particular purpose that are either externally imposed by creditors, grantors, contributors or laws or regulations of other governments or imposed by law through constitutional provisions or enabling legislation. *The unrestricted net position* is remaining assets that do not meet the definition of *net investment in capital assets* or *restricted expendable.*

Fair Value of Financial Instruments: The carrying amounts reported in the combined statements of net position approximate fair value except as described below.

The carrying value of long-term debt and capital lease obligations (including the current portion) was $217,884,917 as of June 30, 2015. The estimated fair value of long-term debt and capital lease obligations (including current portion) was $223,253,248 at June 30, 2015. The fair value of long-term debt related to fixed interest long-term debt and capital lease obligations was estimated using discounted cash flows, based on the Primary Health System's incremental borrowing rates or from quotes obtained from investment advisors. The fair value of long-term debt related to variable rate debt approximates its carrying value.

Subsequent Events: The Primary Health System evaluated all events or transactions that occurred after June 30, 2015 through September 17, 2015 , the date the combined financial statements were available to be issued.

NOTE B--NET PATIENT SERVICE REVENUE

A reconciliation of the amount of services provided to patients at established rates by the Primary Health System to net patient service revenue as presented in the combined statements of revenue, expenses and changes in net position for the year ended June 30, 2015 is as follows:

	Primary Health System
Inpatient service charges	$ 1,231,642,020
Outpatient service charges	934,797,502
Gross patient service charges	2,166,439,522
Less: Contractual adjustments and other discounts	1,311,598,641
Charity care	92,023,486
Estimated provision for bad debts	92,953,845
	1,496,575,972
Net patient service revenue	$ 669,863,550

Charity Care and Community Benefit: The Private Act of the State of Tennessee establishing the Primary Health System obligates the Primary Health System to make its facilities and patient care programs available to the indigent residents of Hamilton County to the extent of funds appropriated by Hamilton County and adjusted operating profits, as defined. The annual appropriation from Hamilton County totaled $1,500,000 for fiscal year 2015. Total charity care charges for services provided to the certified indigent residents of Hamilton County (net of the appropriation) were approximately $7,373,000 for the year ended June 30, 2015 for the Primary Health System.

In addition to charity care provided to specific patients within the hospital setting, the Primary Health System also provides unreimbursed services to the community which includes free and low cost health screenings. The Primary Health System also hosts health fairs and helps sponsor many other events that are free to the public and are spread throughout the year in various community locations.

The Primary Health System's Community Relations department includes HealthLink Plus, a free adult membership program with over 13,000 members in the Chattanooga Statistical Metropolitan Service Area. The Community Relations department hosts several free community events throughout the year utilizing the services of physicians, nurses, volunteers, educators, registered dietitians, social workers, secretaries and management personnel of the Primary Health System.

The Primary Health System's consumer call center, Erlanger HealthLink (423-778-LINK) is a free call center staffed by RN's to answer health questions, offer free physician referrals and to register participants in the programs offered by Community Relations, Women's & Infant Services and other departments and divisions of the Primary Health System.

Uncompensated Care Costs: The following table summarizes the estimated total uncompensated care costs (based on the ratio of total operating revenue and expenses) provided by Erlanger Medical Center as defined by the State of Tennessee for the year ended June 30, 2015:

Uncompensated cost of TennCare/Medicaid	$	31,782,618
Traditional charity uncompensated costs		26,681,372
Bad debt cost		26,649,921
Total estimated uncompensated care costs	$	85,113,911

The uncompensated cost of TennCare/Medicaid is estimated by taking the estimated cost of providing care to the TennCare/Medicaid patients less payments from the TennCare and Medicaid programs. The payments exclude revenues from essential access and other, one-time supplemental payments from TennCare of approximately $17,415,000 for the year ended June 30, 2015 and such payments are not guaranteed for future periods.

Revenue from Significant Payers: Gross patient service charges related to the Medicare program accounted for approximately 31.6% of the Primary Health System's patient service charges for the year ended June 30, 2015. Gross patient service charges related to the TennCare/Medicaid programs accounted for approximately 22.6% of the Primary Health System's patient service charges for the year ending June 30, 2015. TennCare typically reimburses providers at an amount less than their cost of providing services to TennCare patients. At June 30, 2015, the

Primary Health System has a credit concentration related to the Medicare and TennCare programs.

During 2015, the Primary Health System recognized revenue from these programs related to trauma fund payments of approximately $1,111,000. Further, during 2015, the Primary Health System received disproportionate share payments of approximately $5,030,000 which have not been recognized as revenue. All such amounts will be recognized when the Primary Health System's eligibility to receive such funds has been confirmed. Such amounts are subject to audit and future distributions under these programs are not guaranteed. In 2015 the Primary Health System also received and recognized a net payment of $18,781,788 from the Public Hospital Supplemental Payment Pool. Such amounts are expected to be received as long as the current TennCare waiver is intact.

Laws and regulations governing the Medicare and TennCare/Medicaid programs are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates, as they relate to revenue recognized from these programs, will change by a material amount in the near term. The estimated reimbursement amounts are adjusted in subsequent periods as cost reports are prepared and filed and as final settlements are determined. Final determination of amounts earned under prospective payment and cost reimbursement activities is subject to review by appropriate governmental authorities or their agents. Management believes that adequate provisions have been made for adjustments that may result from final determination of amounts earned under Medicare and Medicaid programs. The effect of prior year cost report settlements, or changes in estimates, decreased net patient service revenue by approximately $1,770,000 in 2015.

The Primary Health System has also entered into reimbursement agreements with certain commercial insurance companies, health maintenance organizations and preferred provider organizations. The basis for reimbursement under these agreements includes prospectively determined rates, per diems and discounts from established charges.

NOTE C--CASH AND CASH EQUIVALENTS

Cash and cash equivalents reported on the combined statements of net position include cash on hand and deposits with financial institutions including demand deposits and certificates of deposit, as well as, money market accounts that are held in investment accounts and meet the definition of a cash equivalent.

Cash and cash equivalents consist of the following:

	Primary Health System
Demand deposits	$ 90,410,005
Cash on hand	11,479
Cash equivalents	2,221,018
	$ 92,642,502

Bank balances consist of the following at June 30, 2015:

	Primary Health System
Insured (FDIC)	$ 599,794
Collateralized under the State of Tennessee Bank Collateral Pool	90,481,991
	$ 91,081,785

The Primary Health System's deposits would be exposed to custodial credit risk if they are not covered by depository insurance and the deposits are uncollateralized or are collateralized with securities held by the pledging financial institution's trust department or agent but not in the depositor government's name. The risk is that, in the event of the failure of a depository financial institution, the Primary Health System will not be able to recover deposits or will not be able to recover collateral securities that are in the possession of an outside party.

NOTE D--DISAGGREGATION OF RECEIVABLE AND PAYABLE BALANCES

Patient Accounts Receivable, Net: Patient accounts receivable and related allowances are as follows at June 30, 2015:

	Primary Health System
Gross patient accounts receivable	$ 359,183,176
Estimated allowances for contractual adjustments and uncollectible accounts	(265,395,717)
Net patient accounts receivable	$ 93,787,459

Other Current Assets: Other current assets consist of the following at June 30, 2015:

	Primary Health System
Prepaid expenses	$ 4,319,594
Other receivables	7,512,679
Total other current assets	$ 11,832,273

Accounts Payable and Accrued Expenses: Accounts payable and accrued expenses consist of the following at June 30, 2015:

	Primary Health System
Due to vendors	$ 48,638,243
Other	4,285,022
Total accounts payable and accrued expenses	$ 52,923,265

Other Long-Term Liabilities: Other long-term liabilities, and the related activity, consist of the following:

	Balance at Beginning of Year	***Unearned Revenue Recognized***	***Payments /Other***	***Balance at End of Year***
Compensated absences	$ 10,638,408	$ -	$ -	$ 10,638,408
Medical malpractice	5,066,000	-	(131,100)	4,934,900
Job injury program	1,253,139	-	-	1,253,139
Interest rate swaps	3,982,646	-	(3,982,646)	-
Deferred revenue	2,973,643	(393,607)	-	2,580,036
Other	-	-	89,760	89,760
Total other long-term liabilities	$ 23,913,836	$ (393,607)	$ (4,023,986)	$ 19,496,243

NOTE E--NET PROPERTY, PLANT AND EQUIPMENT

Net property, plant and equipment activity for the Primary Health System consisted of the following:

	Balance at June 30, 2014	*Additions*	*Reductions/ Transfers*	*Balance at June 30, 2015*
Capital assets:				
Land and improvements	$ 25,966,917	$ 152,048	$ (5,126,037)	$ 20,992,928
Buildings	233,622,494	2,986,741	(6,858,056)	229,751,179
Equipment	376,690,494	15,058,319	(4,369,827)	387,378,986
	636,279,905	18,197,108	(16,353,920)	638,123,093
Accumulated depreciation :				
Land and improvements	(12,072,718)	(332,824)	3,624,843	(8,780,699)
Buildings	(176,094,670)	(6,341,721)	3,389,921	(179,046,470)
Equipment	(304,859,236)	(18,450,543)	4,207,750	(319,102,029)
	(493,026,624)	(25,125,088)	11,222,514	(506,929,198)
Capital assets net of accumulated depreciation	143,253,281	(6,927,980)	(5,131,406)	131,193,895
Construction in progress	5,291,923	18,338,139	(12,697,599)	10,932,463
	$ 148,545,204	$ 11,410,159	$ (17,829,005)	$ 142,126,358

Construction in progress at June 30, 2015 consists of various projects for additions and renovations to the Primary Health System's facilities. The estimated cost to complete construction projects is approximately $85,000,000.

During 2012, the Primary Health System entered into an agreement to sell certain professional office buildings (POBs) and concurrently entered into agreements to lease space from the purchaser. The sales price of the POBs was approximately $13,333,000, and a gain of approximately $6,695,000 was realized. Since the Primary Health System is leasing back certain space, a portion of the gain has been deferred and is being recognized over the terms of the leases. Amortization of the deferred gain is included in non-operating revenue (expenses) for the year ended June 30, 2015. The leases entered into (or committed to) under this sale/leaseback agreement include certain leases which meet the criteria for capitalization and are included in Note M.

NOTE F--INVESTMENTS AND ASSETS LIMITED AS TO USE

The Primary Health System invests in United States government and agency bonds, municipal bonds, corporate debt, certificates of deposit and short-term money market investments that are in accordance with the Primary Health System's investment policy. Temporary investments at June 30, 2015 consist primarily of cash equivalents, government bonds and commercial paper.

The carrying and estimated fair values for long-term investments, and assets limited as to use, by type, at June 30, 2015 are as follows:

	Primary Health System
U.S. Government and agency bonds, including municipal bonds, mutual funds, and other	$ 132,355,866
Corporate bonds and commercial paper	41,572,069
Short-term investments and cash equivalents	12,916,366
Total investments and assets limited as to use	$ 186,844,301

Assets limited as to use are designated for the following purposes:

	Primary Health System
Capital investment funds	$ 102,544,397
Under bond indentures - held by trustees	76,706,179
Self-insurance trust	5,645,447
Health plan trust	1,623,416
	$ 186,519,439

Assets limited as to use for capital improvements are to be used for the replacement of property and equipment or for any other purposes so designated.

Funds held by trustees under bond indenture at June 30 are as follows:

	Primary Health System
Debt service reserve funds	$ 6,195,383
Construction fund	70,510,796
Total funds held by trustees under bond indenture	$ 76,706,179

The debt service reserve fund is to be used only to make up any deficiencies in other funds related to the Hospital Revenue and Refunding Bonds Series 2004. The construction fund may be used for various construction and renovation projects related to the Series 2014 bonds.

The Primary Health System's investment policy specifies the types of investments which can be included in board-designated assets limited as to use, as well as collateral or other security requirements. The investment policy also specifies the maximum maturity of the portfolio of board-designated assets. Assets limited as to use and held by trustees are invested as permitted by the bond indenture.

Custodial Credit Risk: The Primary Health System's investment securities are exposed to custodial credit risk if the securities are uninsured, are not registered in the name of the Primary Health System, and are held by either the counterparty or the counterparty's trust department or agent but not in the Primary Health System's name. The risk is that, in the event of the failure of the counterparty to a transaction, the Primary Health System will not be able to recover the value of the investment or collateral securities that are in the possession of an outside party.

As of June 30, 2015, the Primary Health System's investments, including assets limited as to use, were comprised of various short-term investments, U.S. government and government agency bonds, municipal obligations, corporate bonds, commercial paper, and other U.S. Treasury obligations. Substantially all of the Primary Health System's investments, including assets limited as to use, are uninsured or unregistered. Securities are held by the counterparty, or by its trust department or agent, in the Primary Health System's name.

Concentration of Credit Risk: This is the risk associated with the amount of investments the Primary Health System has with any one issuer that exceeds 5% or more of its total investments. Investments issued or explicitly guaranteed by the U.S. Government and investments in mutual funds, external investment pools, and other pooled investments are excluded from this requirement. The Primary Health System's investment policy does not restrict the amount that may be held for any single issuer. At June 30, 2015, none of the Primary Health System's investments with any one issuer exceed 5% of its total investments except certain U.S. Government agencies.

Credit Risk: This is the risk that an issuer or other counterparty to an investment will not fulfill its obligations. GASB No. 40 requires that disclosure be made as to the credit rating of all debt security investments except for obligations of the U.S. Government or obligations explicitly guaranteed by the U.S. Government. The Primary Health System's investment policy provides guidelines for its fund managers and lists specific allowable investments.

The credit risk profile of the Primary Health System's investments, including assets limited as to use (excluding U.S. Government securities), as of June 30, 2015, is as follows:

Investment Type	*Balance as of June 30, 2015*	*Rating*				
		AAA	*AA*	*A*	*BBB*	*N/A*
U.S Government agency bonds	$ 63,486,611	$ 61,980,956	$ 1,505,655	$ -	$ -	$ -
Municipal bonds	21,187,282	12,730,094	6,746,950	1,710,238	-	-
Bond mutual funds	5,593,772	5,593,772	-	-	-	-
Corporate bonds and commercial paper	36,093,132	-	-	36,093,132	-	-
Cash equivalents	12,745,231	-	-	-	-	12,745,231
Total investments	$ 139,106,028	$ 80,304,822	$ 8,252,605	$ 37,803,370	$ -	$ 12,745,231

Interest Rate Risk: This is the risk that changes in interest rates will adversely affect the fair value of an investment. The Primary Health System's investment policy authorizes a strategic asset allocation that is designed to provide an optimal return over the Primary Health System's investment horizon and within specified risk tolerance and cash requirements.

The distribution of the Primary Health System's investments, including assets limited as to use, by maturity as of June 30, 2015, is as follows:

Investment Type	*Balance as of June 30, 2015*	*Remaining Maturity*				
		12 months or less	*13-24 Months*	*25-60 Months*	*Over 60 Months*	*N/A*
U.S. Government bonds and agency funds	$ 111,224,887	$ 40,933,561	$ 26,492,971	$ 15,186,259	$ 28,612,096	$ -
Municipal bonds	21,187,282	11,629,322	3,065,355	6,492,605	-	-
Bond mutual funds	5,593,772					5,593,772
Corporate bonds and commercial paper	36,093,132	36,093,132	-	-	-	-
Cash equivalents	12,745,228	12,745,228	-	-	-	-
Total investments	$ 186,844,301	$101,401,243	$ 29,558,326	$ 21,678,864	$ 28,612,096	$ 5,593,772

NOTE G--LONG-TERM DEBT

Long-term debt at June 30, 2015 consists of the following:

	Primary Health System
Revenue and Refunding Bonds, Series 2014A, including bond premium of $8,511,142	$ 158,431,142
Revenue and Refunding Bonds, Series 2004, net of bond discount of $374,681 and including bond issue premium of $719,347	40,429,666
Total bonds payable	198,860,808
2014B Note payable	12,000,000
Other loans	644,748
Capital leases - Note M	6,379,361
	217,884,917
Less: current portion	(4,782,194)
	$ 213,102,723

On December 1, 2014, the Primary Health System issued $149,920,000 Series 2014A bonds for the purpose of advance refunding $20,615,000 of the outstanding Series 2004 bonds (described below), $30,300,000 of the outstanding Series 2000 bonds, $17,375,000 of the Series 1998A bonds, and $27,465,000 of the outstanding Series 1997A bonds. The Primary Health System also utilized the proceeds to pay certain issuance costs and deposited a portion of the bond proceeds in the amount of $71,000,000 into a construction fund. The advance refunding of the of the Series 2004 bonds, Series 1998A bonds, and 1997A bonds resulted in a loss of $1,116,755 that is reported as a deferred outflow of resources and will be amortized over the term of the Series 2014A bonds.

The Series 2014A bonds consist of series bonds maturing annually beginning October 1, 2016 through 2034 and term bonds maturing on October 1, 2039 and 2044. The term bonds are subject to mandatory sinking fund redemption beginning October 1, 2035. The Series 2014A bonds are also subject to redemption by the Primary Health System at any interest payment date at a redemption price equal to the principal amount plus accrued interest.

Interest rates for the Series 2014A bonds are as follows:

Series bonds	- 3.0% to 5.0%
Term bonds	- 4.125% to 5.0%

In conjunction with the issuance of the Series 2014A bonds, the Primary Health Systems issued a $12,000,000 note payable (2014B note) through a financial institution to advance refund the remaining $11,775,000 of outstanding Series 1997A bonds and pay issuance costs. Principal payments of $100,000 are due annually beginning October 1, 2018 until the maturity date of October 1, 2021. The 2014B note bears interest, payable monthly, at a variable rate equal to the 1-month London Interbank Offered Rate plus a margin ranging from .73% to 2.25% based on the debt rating of the Primary Health System. The applicable interest rate at June 30, 2015 was 1.174%.

On January 1, 2004, the Primary Health System issued $85,000,000 insured Series 2004 bonds for the purpose of refunding $80,925,000 of the total outstanding Series 1993 bonds. The Primary Health System also utilized the proceeds to pay certain issuance costs and establish a debt service fund. The outstanding Series 2004 bonds mature annually on October 1 through 2022 in varying amounts. The Series 2004 bonds maturing after October 1, 2019 may be redeemed by the Primary Health System after October 1, 2019 at a redemption price equal to the principal amount plus accrued interest. Interest rates for the outstanding Series 2004 bonds range from 4.0% to 5.0%.

During 2015, a portion of the Series 2004 bonds totaling $20,615,000 were defeased with the issuance of the Series 2014A bonds proceeds through the deposit of funds into an irrevocable escrow account in amounts sufficient to pay the principal and interest when due. A portion of the defeased Series 2004 bonds totaling $8,135,000 has been redeemed. The escrow balance for payment of the remaining principal and interest totaled $13,903,430 at June 30, 2015.

The Series 2014A bonds, Series 2004 bonds and 2014B note were issued on parity, with respect to collateral, and are also secured by a mortgage on a portion of the Primary Health System's main campus. The trust indentures and related documents underlying the bonds contain certain covenants and restrictions. As of June 30, 2015, management believes the Primary Health System is in compliance with all such covenants.

In August 2000, the Primary Health System issued $47,300,000 insured Series 2000 bonds for the purpose of refunding $40,000,000 of the outstanding Series 1987 bonds and funding a debt service reserve fund and to pay issuance costs. The outstanding Series 2000 bonds were redeemed with the proceeds of the Series 2014A bonds during 2015.

The Primary Health System's 1997A and 1998A Hospital Revenue Bonds were issued to fund capital improvements for Erlanger Medical Center and establish a debt service reserve fund (1998A only). The outstanding Series 1997A and Series 1998A bonds were redeemed with the proceeds of the Series 2014A bonds and 2014B note during 2015.

Year Ended June 30, 2015

Long-term debt activity for the Primary Health System for the year ended June 30, 2015 consisted of the following:

	Balance at June 30, 2014	*Additions/ Amortizations*	*Reductions/ Accretions*	*Balance at June 30, 2015*
Bonds Payable				
Series 2014	$ -	$ 158,600,880	$ 169,738	$ 158,431,142
Series 2004	66,859,457	68,518	26,498,309	40,429,666
Series 2000	32,558,296	-	32,558,296	-
Series 1998A	18,159,154	265,846	18,425,000	-
Series 1997A	41,000,000	-	41,000,000	-
Total bonds payable	158,576,907	158,935,244	118,651,343	198,860,808
2014B Note payable	-	12,000,000	-	12,000,000
Other loans	4,978,158	865,000	5,198,410	644,748
Capital leases	6,575,290	-	195,929	6,379,361
Total long-term debt	$ 170,130,355	$ 171,800,244	$ 124,045,682	$ 217,884,917

The Primary Health System's scheduled principal and interest payments (estimated for variable rate debt based on rates at June 30, 2015) on bonds payable and other long-term debt (excluding capital leases) are as follows for the years ending June 30:

Year Ending June 30,	*Principal*	*Interest*	*Total*
2016	$ 4,701,350	$ 9,265,265	$ 13,966,615
2017	4,643,398	9,048,385	13,691,783
2018	4,575,000	8,854,983	13,429,983
2019	5,060,000	8,635,334	13,695,334
2020	5,295,000	8,395,029	13,690,029
2021-2025	26,425,000	38,156,610	64,581,610
2026-2030	25,850,000	33,545,955	59,395,955
2031-2035	32,675,000	26,695,969	59,370,969
2036-2040	41,330,000	17,907,853	59,237,853
2041-2045	52,095,000	6,765,875	58,860,875
TOTAL	$ 202,649,748	$ 167,271,258	$ 369,921,006

NOTE H--PENSION PLAN

Plan Description: The Primary Health System sponsors the Chattanooga-Hamilton County Hospital Authority Pension Retirement Plan & Trust (the Plan), a single-employer, non-contributory defined benefit pension plan covering employees meeting certain age and service requirements.

The Primary Health System has the right to amend, in whole or in part, any or all of the provisions of the plan. Effective July 1, 2009, the plan was amended to be closed to new employees or rehires, and to further clarify the maximum years of service to be 30. During June 2014, the plan was amended to freeze the accrual of additional benefits.

Benefits Provided: In addition to normal retirement benefits, the Plan also provides for early retirement, disability and death benefits. Retirement benefits are calculated as a percent of the employee's average monthly salary for the last 10 calendar years times the employee's years of service. Employees earn full retirement benefits after 30 years of service. Early retirement benefits are available once an employee has reached age 55 and 10 years of service at a reduced rate based on age. Disability retirement benefits are available after 3 years of credited service, determined in the same manner as retirement benefits and are payable at the normal retirement date. Death benefits equal the actuarial equivalent value of the employee's vested accrued benefit as of the date of death. An employee who terminates service for other reasons after three years of credited service will receive retirement benefits at the normal retirement date

Employees Covered: At January 1, 2015, the following employees were included in the Plan:

Active employees	2,103
Inactive employees with deferred benefits	1,364
Inactive employees currently receiving benefits	179
	3,646

Contributions: The Primary Health System funds the plan as contributions are approved by the Board of Trustees based on an actuarially determine rate recommended by an independent actuary. The actuarially determined rate is the estimated amount necessary to finance the costs of benefits earned during the year with an additional amount to finance any unfunded accrued liability.

Net Pension Liability: The Primary Health System's net pension liability was measured as of June 30 2015, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of January 1, 2015. The total pension liability in the

actuarial valuation was determined using the following actuarial assumptions, applied to all periods included in the measurement:

Inflation	2.5%
Salary increases	N/A
Investment rate of return	7.5%
Discount rate	7.5%

Mortality rates were based on the RP-2014 Mortality for Employees, Healthy Annuitants, and Disabled Annuitants, with generational projection per MP-2014.

The long-term expected rate of return on pension plan investments was determined using a method in which best-estimate ranges of expected future real rates of return (expected returns, net of pension plan investment expense and inflation) are developed for each major asset class. The target allocation and best estimates of arithmetic real rates of return for each major asset class are summarized as follows:

Asset Class	*Target Allocation*	*Long-term Expected Real Rate of Return*
Fixed income	10.00%	1.54%
Short-term bonds	5.00%	1.08%
Domestic equities	25.00%	5.71%
Global equities	17.50%	5.76%
Foreign equities	20.00%	6.01%
Real estate	5.00%	5.19%
Hedge funds	17.50%	5.50%

The pension plan's fiduciary net position was projected to be available to make all projected future benefit payments of current active and inactive employees assuming the actuarially determine contributions are made each year, although not required by the funding policy. Therefore, the discount rate for determining the total pension liability is equal to the long-term expected rate of return on pension plan investments.

Changes in the Net Pension Liability:

Changes in the Primary Health System's net pension liability are as follows for the year ended June 30, 2015:

	Total Pension Liability	*Plan Fiduciary Net Position*	*Net Pension Liability*
Balance, June 30, 2014	$ 130,245,072	$ 85,753,713	$ 44,491,359
Interest	9,278,335	-	9,278,335
Liability gains or losses	(386,473)	-	(386,473)
Assumptions changes	2,284,765	-	2,284,765
Benefit payments	(13,308,452)	(13,308,452)	-
Administrative expenses	-	(515,072)	515,072
Investment income	-	5,922,518	(5,922,518)
Investment gains or losses	-	(2,596,923)	2,596,923
Employer contributions	-	1,000,000	(1,000,000)
Balance, June 30, 2013	$ 128,113,247	$ 76,255,784	$ 51,857,463

The following presents the net pension liability of the Primary Health System calculated using the current discount rate of 7.5 percent, as well as what the net pension liability would be if it were calculated using a discount rate that is 1-percentage-point lower (6.5%) or 1-percentage-point higher (8.5%) than the current rate:

	1% Decrease 6.5%	*Current Rate 7.5%*	*1% Increase 8.5%*
Total pension liability	$ 137,256,238	$ 128,113,247	$ 120,128,551
Fiduciary net position	76,255,784	76,255,784	76,255,784
Net pension liability	61,000,454	51,857,463	43,872,767

Pension Expense and Deferred Outflows and Deferred Inflows of Resources: For the year ended June 30, 2015, the Primary Health System recognized pension expense totaling $4,725,070. At June 30, 2015, the Primary Health System reported deferred outflows of resources and deferred inflows of resources from the following sources:

	Deferred Outflows of Resources	*Deferred Inflows of Resources*
Differences between expected and actual experience	$ -	$ 318,312
Changes of assumptions	1,881,808	-
Differences between projected and actual earnings	2,077,533	-
	$ 3,959,341	$ 318,312

Amounts reported as deferred outflows of resources and deferred inflows of resources related to pensions will be recognized in pension expense as follows:

Year Ending June 30,		
2016	$	854,181
2017		854,181
2018		854,181
2019		854,181
2020		224,312

NOTE I--OTHER RETIREMENT PLANS

The Primary Health System maintains defined contribution plans under Section 403(b) and 401(a) of the IRC which provides for voluntary contributions by employees. The Plans are for the benefit of all employees 25 years of age or older with at least 12 months of employment.

The Primary Health System matches 50% of each participant's contribution up to 2% of the participant's earnings. For eligible employees hired on or after July 1, 2009, the Primary Health System will make profit sharing contributions equal to 3% of their earnings, regardless if the employee is making contributions. Additionally, active employees in the frozen pension plan will receive an additional 2.5% contribution through fiscal year 2019. Employer and employee contributions to the plans were approximately $1,740,000 and $7,500,000, respectively for the year ended June 30, 2015.

NOTE J--POST-EMPLOYMENT BENEFITS OTHER THAN PENSIONS

The Primary Health System sponsored three post-employment benefit plans other than pensions (OPEB) for full-time employees who had reached retirement age, as defined. The respective plans provided medical, dental, prescription drug and life insurance benefits, along with a limited lump-sum cash payment for a percent of the hours in the participant's short-term disability at retirement. The postretirement health, dental and prescription drug plan was contributory and contained other cost-sharing features, such as deductibles and coinsurance. The life insurance plan and the short-term disability were noncontributory.

During 2014, the postretirement health, dental and prescription drug plan were amended to increase the amount of required participant contributions. Additionally, eligibility for the short-term disability was limited to employees that had attained age 55 and completed 10 years of service as of January 1, 2014 or attained age 65 with at least 5 years of service as of this date. The lump-sum payout for the short-term disability was also reduced from 50% to 20% of the amount accumulated. During 2015, all post-employment benefit plans were terminated and no

further benefits will be paid. The termination of these plans reduced other long-term liabilities by approximately $3,650,000 and is reported as a reduction of operating expenses in the combined financial statements.

NOTE K--MEDICAL MALPRACTICE AND GENERAL LIABILITY CLAIMS

As of January 1, 1976, the Primary Health System adopted a self-insurance plan to provide for malpractice and general liability claims and expenses arising from services rendered subsequent to that date. In 1980, the Primary Health System's Self-Insurance Trust Agreement (the Agreement) was amended to include all coverages that a general public liability insurance policy would cover. In 1988, the Agreement was amended and restated to comply with amendments to the Tennessee Governmental Tort Liability Act and to formally include any claims and expenses related to acts of employees of the Primary Health System. The Primary Health System is funding actuarial estimated liabilities through a revocable trust fund with a bank. The trust assets are included as a part of assets limited as to use in the accompanying combined statements of net position. Such amounts in the trust can be withdrawn by the Primary Health System only to the extent there is an actuarially determined excess. The annual deposit to the self-insurance trust fund is determined by management based on known and threatened claims, consultation with legal counsel, and a report of an independent actuary. Losses against the Primary Health System are generally limited by the Tennessee Governmental Tort Liability Act to $300,000 for injury or death to any one person in any one occurrence or $700,000 in the aggregate. However, claims against healthcare practitioners are not subject to the foregoing limits applicable to the Primary Health System. Any such individuals employed by the Primary Health System, excluding employed physicians for which the Primary Health System has purchased insurance coverage, are covered by the Trust to the limits set forth therein.

In the opinion of management, the revocable trust fund assets are adequate at June 30, 2015 to cover potential liability and malpractice claims and expenses that may have been incurred to that date.

The Primary Health System provides for claims and expenses in the period in which the incidence related to such claims occur based on historical experience and consultation with legal counsel. It is the opinion of management that the reserve for estimated losses and loss adjustment expense (LAE) at June 30, 2015 is adequate to cover potential liability and malpractice claims which may have been incurred but not reported (IBNR) to the Primary Health System. Such reserve for IBNR claims reflects a discount rate of 5.5% based on the Primary Health System's expected investment return during the payout period.

NOTE L--COMMITMENTS AND CONTINGENCIES

Litigation: The Primary Health System is subject to claims and suits which arise in the ordinary course of business. In the opinion of management, the ultimate resolution of such pending legal proceedings has been adequately provided for in its combined financial statements, and will not have a material effect on the Primary Health System's results of operations or financial position.

The prior Chief Executive Officer (CEO) resigned from the Primary Health system on December 31, 2011, after an interim CEO (the Executive Vice President) was established December 1, 2011. The interim CEO was replaced by the current CEO, hired on April 1, 2013. The Executive Vice President's employment ended when her leave expired in June, 2013. She has filed a wrongful termination lawsuit against the Primary Health System for $25 million, which the Primary Health System, in conjunction with its Directors and Officers insurance carrier, is currently defending. Management believes that insurance coverage is adequate to cover any settlement. The ultimate outcome of this lawsuit is uncertain and, therefore, no estimate of loss has been recorded in the combined financial statements.

Workers Compensation: The Primary Health System has a job injury program to provide benefits to workers injured in employment-related accidents. This program provides medical and indemnity benefits to employees injured in the course of employment for a period up to 24 months from the date of injury. The Primary Health System has recorded a projected liability that is included in other long-term liabilities in the combined statements of net position. The projected liability was discounted using a 4% rate of return at June 30, 2015.

Healthcare Benefits: The Primary Health System maintains a self-insured healthcare plan to provide reimbursement for healthcare expenses for covered employees. The Primary Health System has estimated and recorded a liability for claims incurred but not reported in the combined financial statements.

Regulatory Compliance: The healthcare industry is subject to numerous law and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, Medicare fraud and abuse, and most recently under the Provision of Health Insurance Portability and Accountability Act of 1996, matters related to patient records, privacy and security. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers, such as the Medicare Recovery Audit Contractor Program. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Compliance with such

laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

In the normal course of business, the Primary Health System continuously monitors and investigates potential issues through its compliance program. Management believes that the Primary Health System is in compliance with applicable laws and regulations or has reported any amounts payable related to known violations, including amounts identified through the Medicare Recovery Audit Contractor program, or similar initiatives, and any settlements will not have a significant impact on the combined financial statements. However, due to the uncertainties involved and the status of ongoing investigations, management's estimate could change in the near future and the amount of the change could be significant.

Health Care Reform: In March 2010, Congress adopted comprehensive healthcare insurance legislation, Patient Care Protection and Affordable Care Act and Health Care and Education Reconciliation Act. The legislation, among other matters, is designated to expand access to coverage to substantively all citizens through a combination of public program expansion and private industry health insurance. Changes to existing TennCare and Medicaid coverage and payments are also expected to occur as a result of this legislation. Implementing regulations are generally required for these legislative acts, which are to be adopted over a period of years and, accordingly, the specific impact of any future regulations is not determinable.

NOTE M--LEASES

Capital: As discussed in Note E, during 2012, the Primary Health System entered into a sale/leaseback arrangement, under which certain leases of office space meet the criteria as capital leases. Interest on these leases has been estimated at 7% per annum.

During 2011, the Primary Health System acquired a parcel of land from the Industrial Development Board of the City of Chattanooga, Tennessee for a nominal amount. The Primary Health System also entered into a project development agreement with a developer to facilitate final design, financing and construction of a medical office building for the benefit of Volkswagen Group of America Chattanooga Operations, LLC (Volkswagen) on this land. The Primary Health System has entered into a forty-year ground lease, with the option of two ten-year renewal terms, of the parcel to the developer. Additionally, in 2012, the Primary Health System has entered into a twenty year lease with the developer for certain space in the medical office building for a wellness center and other operations under a capital lease agreement.

The following is a summary of the property under capital leases by major classes at June 30, 2015:

	Primary Health System
Buildings	$ 6,599,976
Equipment	494,905
	7,094,881
Less: accumulated amortization	(1,762,056)
	$ 5,332,825

The following is a schedule of future minimum lease payments under capital leases:

Year Ending June 30,	
2016	$ 733,585
2017	729,999
2018	744,453
2019	759,311
2020	774,587
2021-2025	3,728,737
2026-2030	4,137,530
2031-2033	1,041,823
Total minimum lease payments	12,650,025
Less: amount representing interest	(6,270,664)
Present value of minimum lease payments	$ 6,379,361

Operating: The Primary Health System rents office space and office equipment under non-cancelable operating leases through 2033, containing various lease terms. The leases have other various provisions, including sharing of certain executory costs. Rent expense under operating leases was approximately $9,810,000 in 2015.

Future minimum lease commitments for all non-cancelable leases with terms in excess of one year are as follows:

Year Ending June 30,	
2016	$ 6,231,365
2017	4,242,932
2018	3,765,250
2019	3,573,659
2020	3,020,973
Thereafter	18,879,687
	$ 39,713,866

Rental Revenues: The Primary Health System leases office space to physicians and others under various lease agreements with terms in excess of one year. Rental revenue recognized for the years ended June 30, 2015 totaled approximately $3,016,000. The following is a schedule of future minimum lease payments to be received:

Year Ending June 30,	
2016	$ 2,131,770
2017	943,730
2018	740,605
2019	532,025
2020	503,251
Thereafter	493,686
	$ 5,345,067

NOTE N--DERIVATIVE FINANCIAL INSTRUMENTS

Simultaneous with the issuance of the $85,000,000 Series 2004 bonds discussed in Note G, the Primary Health System entered into two distinct interest rate swap agreements with a third party (described below) in an effort to take advantage of the differences between taxable and tax-exempt debt. The interest rate swap agreements were terminated during 2015.

With respect to the 1997A Series bonds, the Primary Health System executed a swap agreement whereby the Primary Health System received a variable rate equal to the one-month LIBOR-BBA rate and paid a fixed rate equal to 5.087% on a notional amount of $41,000,000.

With respect to the 1998A Series bonds, the Primary Health System executed a swap agreement whereby the Primary Health System received a fixed rate of 3.932% and pays a variable rate

equal to the Securities Industry and Financial Markets Association (SIFMA) Municipal Swap Index on a notional amount of $16,305,000.

Although these swap instruments were intended to manage exposure to interest rate risks associated with the various debt instruments referred to above, none of these swap agreements were determined to be effective hedges. Accordingly, the changes in the value of the swaps are reflected as a component of non-operating revenues in the combined statements of revenue, expenses and changes in net position. The termination of the swap agreements resulted in a payment of approximately $3,200,000 and a reduction of other long-term liabilities.

NOTE O--MANAGEMENT AGREEMENT

On April 13, 2011, the Primary Health System's Board of Trustees approved a resolution authorizing a management agreement (the Agreement) between the Primary Health System, Hutcheson Medical Center, Inc. and affiliates (collectively, Hutcheson) and the Hospital Authority of Walker, Dade and Catoosa Counties in Georgia (the Hospital Authority).

Under the terms of the Agreement, the Primary Health System proposed general operating policies and directives for Hutcheson; was responsible for the day-to-day management of Hutcheson and provided oversight of ancillary aspects of Hutcheson, such as physician practices, education, research, and clinical services. The Agreement's initial term was to be through March 31, 2021 with the Primary Health System to have the option to extend the agreement for two additional five year terms. The Primary Health System was authorized to terminate the Agreement, without cause, upon written notice at any point subsequent to May 25, 2013. Upon such termination, Hutcheson was to be obligated to make a Termination Payment to the Primary Health System consisting of all expenses then owed by Hutcheson and any outstanding advances under a Line of Credit Agreement, discussed below. Hutcheson could also terminate the agreement without cause at any point subsequent to May 25, 2013 by paying the Termination Payment, as well as the lesser of a) $1,000,000 per year for each year the Agreement has been in place, or b) $1,000,000 less any management fees paid in each Agreement year.

In addition to the Agreement, the Primary Health System agreed to extend a Line of Credit (the Line) to the Hospital Authority. The maximum amount available under the Line was $20,000,000 and at June 30, 2015, the draws on the Line totaled $20,000,000.

The Line called for interest only payments each month on the outstanding balance, based on the London InterBank Offered Rate plus 4% or a rate of 5%, whichever is greater. However, any unpaid interest through March 31, 2013 was deferred and to be paid over a twelve-month period commencing on that date. All outstanding draws were due at the maturity date, which is consistent with the Agreement termination dates, discussed above.

The Line is secured by a Security Agreement on the primary Hutcheson medical campus. Further, the Counties of Walker and Catoosa, Georgia (collectively, the Counties) have provided additional security in the form of guarantees under an Intergovernmental Agreement. Under the Intergovernmental Agreement, the Counties have each agreed to a maximum liability of $10,000,000 to secure the line. The form of such guarantee was to be at the option of the Counties and were to become enforceable upon a notice of default delivered by the Primary Health System. The form of the guarantee selected by the Counties can include a) a payment of 50% by each County of the amounts owing under the Line, b) payments as they become due up to the respective $10,000,000 limits or c) after non-Judicial foreclosure under the Security Agreement, each County could elect to pay 50% of any deficiency between the amount outstanding under the Line and the then fair market value. Both Counties previously agreed to levy annual property taxes, if needed to honor these guarantees.

In June 2013, the Agreement was modified to allow Hutcheson to issue requests for proposals for the lease or sale of Hutcheson properties without creating a breach of the Agreement. As part of the Agreement, Hutcheson committed to obtain alternative financing and repay the line of credit upon the earlier of the replacement financing being obtained by Hutcheson, or June 1, 2014.
In August of 2013, however, Hutcheson terminated the Agreement. In response thereto, the Primary Health System declared Hutcheson to be in default under the Agreement and made formal demand of Hutcheson as to all amounts then due and payable. In February 2014, the Primary Health System filed suit against Hutcheson in order to collect the moneys, including principal, interest and penalties, then due. In response to such filing, Hutcheson has asserted multiple counter claims against the Primary Health System alleging mismanagement and other failures under the Agreement. Additionally, another senior creditor has filed a separate lawsuit against the Primary Health System alleging priority over the Primary Health System's security interest and, presumably, the County guarantees relating to Hutcheson. The litigation is currently pending in the United States District Court in the Northern District of Georgia, Rome Division.

During the pendency of the litigation, Hutcheson's operating entities (Hutcheson Medical Center, Inc. and Hutcheson Medical Division, Inc., but not the Hospital Authority) filed for Chapter 11 bankruptcy protection in the Northern District of Georgia. Such filing automatically stayed the pending litigation to the extent it pertains to Hutcheson's operating entities. As of the date of this Note, the Hutcheson entities, remains in Chapter 11 still with no plan of reorganization. On September 15, 2015, the Bankruptcy Court appointed a Chapter 11 Trustee in order to facilitate a sale of Hutcheson's interests. The Primary Health System remains actively involved in the bankruptcy action to ensure that its interests remain adequately protected.

Regions Bank (Regions) is also a creditor of Hutcheson and initiated related litigation in the U.S. District Court for the Northern District of Georgia in Rome (Case No. 4:14-cv-00191) against the Primary Health System in its effort to protect its interest, if any, in the litigation. Specifically, Regions claims the Primary Health System's interest is subordinate to its interest and seeks a declaration of such priority. Regions claims that Hutcheson owes Regions in excess of $22.3 million that is allegedly a senior debt to the debt Hutcheson owes to the Primary Health System. Regions further claims that the Primary Health System's attempted foreclosure constitutes a breach of the Management Agreement to which Regions is allegedly a third party beneficiary and related contracts. Regions filed a Motion for a temporary restraining order on July 28, 2014, seeking to enjoin the foreclosure proceedings. The Court denied Regions Motion for a temporary restraining order as moot in light of the injunctive relief it granted to Hutcheson in the related litigation. Regions filed a second Motion for a temporary restraining order on October 15, 2014, which was heard on October 24, 2014. The Court again denied the Motion for a temporary restraining order as moot due to the injunctive relief granted to Hutcheson in the related litigation. The Primary Health System filed a Motion to Dismiss in the Regions suit, which was granted on October 29, 2014 and dismissed all claims against the Primary Health System in their entirety. Regions appealed the dismissal to the 11th Circuit. To date, that court has yet to rule on the appeal.

NOTE P--OTHER REVENUE

The American Recovery and Reinvestment Act of 2009 and the Health Information Technology for Economic and Clinical Health (HITECH) Act established incentive payments under the Medicare and Medicaid programs for certain healthcare providers that use certified Electronic Health Record (EHR) technology. To qualify for incentive payments, healthcare providers must meet designated EHR meaningful use criteria as defined by the Centers for Medicare & Medicaid Services (CMS). Incentive payments are awarded to healthcare providers who have attested to CMS that applicable meaningful use criteria have been met. Compliance with meaningful use criteria is subject to audit by the federal government or its designee and incentive payments are subject to adjustment in a future period. The Primary Health System recognizes revenue for EHR incentive payments when substantially all contingencies have been met. During 2015, the Primary Health System recognized approximately $1,456,000 of other revenue related to EHR incentive payments.

NOTE Q--CONDENSED FINANCIAL INFORMATION

The following is condensed, financial information related to the discretely presented component units as of and for the year ended June 30, 2015:

	ContinuCare	*Cyberknife*
Due from other governments	$ 289,425	$ 120,400
Other current assets	10,998,935	615,455
Total Current Assets	11,288,360	735,855
Net property, plant and equipment	4,767,830	3,691,914
Other assets	500,663	56,482
Total Assets	$ 16,556,853	$ 4,484,251
Due to other governments	$ 130,037	$ -
Other current liabilities	2,623,920	3,051,492
Total Current Liabilities	2,753,957	3,051,492
Long-term debt and capital lease obligations	25,035	85,186
Total Liabilities	2,778,992	3,136,678
Net position		
Unrestricted	9,064,490	691,234
Net investment in capital assets	4,713,371	656,339
Total Net Position	13,777,861	1,347,573
Total Liabilities and Net Position	$ 16,556,853	$ 4,484,251
Net patient and operating revenue	$ 27,536,041	$ 1,935,000
Operating expenses:		
Salaries, wages and benefits	13,841,457	222,148
Supplies and other expenses	12,705,142	663,305
Depreciation	522,014	626,840
Total Operating Expenses	27,068,613	1,512,293
Operating Income	467,428	422,707
Nonoperating expenses	(253,723)	(148,025)
Change in Net Position	213,705	274,682
Net Position at Beginning of Period	13,564,156	1,072,891
Net Position at End of Period	$ 13,777,861	$ 1,347,573

ContinuCare owes the Primary Health System for various services, supplies, and rents provided, or expenses paid on its behalf. Actual expenses incurred related to these services were $2,022,540 in 2015. In addition, ContinuCare provides staffing, contract nurse visits, and administrative services to the Primary Health System. Revenues from such services were $538,569 for the year ended June 30, 2015. Amounts due at June 30, 2015 are included in amounts due to/from other governments in the accompanying combined financial statements. As of June 30, 2015, Cyberknife owes the Primary Health System for various services, supplies and

rents provided, or expenses paid on its behalf. The Primary Health System owes Cyberknife for radiation services provided by Cyberknife to the Primary Health System's patients. Revenues related to those services provided to the Primary Health System were $1,935,000 in 2015. Amounts due at June 30, 2015 are included in amounts due to/from other governments in the accompanying combined financial statements.

Required Supplementary Information

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Schedule of Changes in Net Pension Liability and Related Ratios

Year Ended June 30, 2015

Total pension liability	
Interest	$ 9,278,335
experience	(386,473)
Changes of assumptions or inputs	2,284,765
Benefit payments	(13,308,452)
Net change in total pension liability	(2,131,825)
Total pension liability, beginning of year	130,245,072
Total pension liability, end of year	$ 128,113,247
Plan fiduciary net position	
Contributions - employer	$ 1,000,000
Net investment income, net	3,325,595
Benefit payments	(13,308,452)
Administrative expense	(515,072)
Net change in plan fiduciary net position	(9,497,929)
Plan fiduciary net position, beginningof year	85,753,713
Plan fiduciary net position, end of year	$ 76,255,784
Net pension liability, end of year	$ 51,857,463
Fiduciary net position as a percentage of the total pension liability	59.52%
Covered-employee payroll	$ 117,027,000
Net pension liability as a percentage of covered-employee payroll	44.31%

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Schedule of Actuarial Contributions

Year Ended June 30, 2015

	2015	2014	2013	2012	2011	2010	2009	2008	2007	2006
Actuarially determine contributions	$ 4,364,255	$ 12,832,292	$ 11,165,101	$ 10,367,973	$ 8,833,977	$ 7,501,004	$ 7,192,948	$ 6,731,386	$ 8,261,320	$ 7,717,419
Actual employer contributions	1,000,000	-	11,165,101	10,367,970	8,833,977	7,501,004	7,192,000	6,172,593	7,590,497	8,371,479
Contribution deficiency	$ 3,364,255	$ 12,832,292	$ -	$ 3	$ -	$ -	$ 948	$ 558,793	$ 670,823	$ (654,060)
Covered-employee payroll	$ 117,027,311	$ 121,093,695	$ 138,807,819	$ 147,947,134	$ 144,176,724	$ 139,291,860	$ 138,478,848	$ 127,662,977	$ 134,278,637	$ 137,097,040
Contributions as a percentage of covered-employee payroll	0.85%	0.00%	8.04%	7.01%	6.13%	5.39%	5.19%	4.84%	5.65%	6.11%

Notes to Schedule:

Valuation date:	Actuarially determined contribution rates are calculated as of June 30, one year prior to the end of the fiscal year in which contributions are reported.
Actuarial cost method:	Entry age
Amortization method:	Level dollar
Amortization period:	19 years
Asset valuation method:	4-year smoothed market
Inflation:	2.5%
Lump sum interest rate:	4.0% (4.5% in prior year)
Salary increases:	N/A
Investment rate of return:	7.50%
Retirement age:	Normal retirement at 65 years, early retirement at 55 years with 10 years of service
Mortality:	RP-2014 Mortality for Employees, Health Annuitiants, and Disabled Annutitants with general projection per MP-2014 in 2015 RP-2000 Mortality for Employees, Health Annuitiants, and Disabled Annutitants projected to 2018 per Scale AA in prior year

Description	Section / Item
List Of Erlanger Patient Transfer Agreements	C-III-1

MediTract

Current Patient Transfer Agreements-01072016

Department	Organization Name	Contract Number	Contract Type	Vendor Other Party	Status	Effective Date	Expiration Date	Description
7157 - Renal Transplant Donor	Erlanger Health System	2002.4290C	Patient Transfer Agreement	Sweetwater Dialysis Center	Current	06/19/2009	Evergreen	Provide Renal Transplantation and other services to Clinic patients
7158 - Renal Transplant Administration	Erlanger Health System	2002.1508C	Patient Transfer Agreement	Dialysis Clinic, Inc	Current	03/23/1998	Evergreen	DCI Patient Transfer Agreements (all facilities -- see attachments)
7158 - Renal Transplant Administration	Erlanger Health System	2002.1636C	Patient Transfer Agreement	Rhea County Medical Center	Current	09/01/1989	Evergreen	Renal Transplant Services (Transfer)
8028 - Patient Logistics	Erlanger Health System	2002.1292C	Patient Transfer Agreement	Life Care Center of Collegedale	Current	01/01/1995	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1293C	Patient Transfer Agreement	Marshall Medical Center North	Current	02/01/2000	Evergreen	Pediatric Patient Transfer
8028 - Patient Logistics	Erlanger Health System	2002.1294C	Patient Transfer Agreement	Life Care Center of Red Bank	Current	01/01/1995	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1306C	Patient Transfer Agreement	Tender Loving Care	Current	01/01/1995	Evergreen	Hospice Transfer
8028 - Patient Logistics	Erlanger Health System	2002.1317C	Patient Transfer Agreement	LaFayette Health Care	Current	01/31/1995	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1321C	Patient Transfer Agreement	Jefferson Memorial Hospital	Current	10/22/2004	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1336C	Patient Transfer Agreement	Mountain Creek Manor	Current	01/20/1995	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1337C	Patient Transfer Agreement	Murphy Medical Center	Current	04/01/2000	Evergreen	Pediatric Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1342C	Patient Transfer Agreement	Northside Hospital	Current	04/10/1992	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1363C	Patient Transfer Agreement	Renaissance Rehabilitation	Current	04/26/1990	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1372C	Patient Transfer Agreement	Rivermont Convalescent Center	Current	01/25/1995	Evergreen	Patient Transfer
8028 - Patient Logistics	Erlanger Health System	2002.1384C	Patient Transfer Agreement	The Health Center at Standifer Place	Current	06/18/2012	Evergreen	Patient Transfer

Department	Organization Name	Contract Number	Contract Type	Vendor Other Party	Status	Effective Date	Expiration Date	Description
8028 - Patient Logistics	Erlanger Health System	2002.1385C	Patient Transfer Agreement	Shepherd Hills Health Care Center	Current	01/25/1995	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1388C	Patient Transfer Agreement	Methodist Medical Center	Current	02/06/2002	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1389C	Patient Transfer Agreement	Brookewood Medical Center	Current	06/27/2012	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1390C	Patient Transfer Agreement	Continuum Care Corporation d/b/a Spring City Health Care Center	Current	02/01/1999	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1430C	Patient Transfer Agreement	Bledsoe Community Medical Center	Current	06/27/2012	Evergreen	Patient Transfer
8028 - Patient Logistics	Erlanger Health System	2002.1446C	Patient Transfer Agreement	The University of Tennessee Medical Center	Current	05/29/2002	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1461C	Patient Transfer Agreement	Erlanger Bledsoe	Current	10/01/2001	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1483C	Patient Transfer Agreement	Cookeville Regional Medical Center	Current	02/10/2010	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1498C	Patient Transfer Agreement	Scott County Hospital	Current	01/11/2001	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1499C	Patient Transfer Agreement	Wellmont Health Systems	Current	06/30/2001	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1502C	Patient Transfer Agreement	Laughlin Memorial Hospital, Inc	Current	11/23/2011	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1539C	Patient Transfer Agreement	Fort Sanders Park West Medical Center	Current	10/22/1999	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1550C	Patient Transfer Agreement	Johnson City Medical Center	Current	05/29/2002	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1576C	Patient Transfer Agreement	Life Care Center of Chattanooga	Current	01/25/1995	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1594C	Patient Transfer Agreement	St Barnabas Nursing Home	Current	01/25/1995	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1599C	Patient Transfer Agreement	North Jackson Hospital	Current	02/01/2000	Evergreen	Pediatric Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1605C	Patient Transfer Agreement	National Health Care of Rossville	Current	05/17/2012	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1606C	Patient Transfer Agreement	National Health Care of Fort Oglethorpe	Current	05/22/2012	Evergreen	Patient Transfer Agreement

Department	Organization Name	Contract Number	Contract Type	Vendor Other Party	Status	Effective Date	Expiration Date	Description
8028 - Patient Logistics	Erlanger Health System	2002.1607C	Patient Transfer Agreement	National Healthcare of Dunlap	Current	06/20/2012	06/19/2016	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1608C	Patient Transfer Agreement	National Health Care of Athens	Current	05/15/2012	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1623C	Patient Transfer Agreement	Shriners Hospitals for Children	Current	07/01/2000	Evergreen	Pediatric Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1634C	Patient Transfer Agreement	Rhea Medical Center	Current	02/06/2002	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1650C	Patient Transfer Agreement	Siskin Hospital for Physical Rehabilitation	Current	02/09/1990	Evergreen	Shared Services
8028 - Patient Logistics	Erlanger Health System	2002.1670C	Patient Transfer Agreement	Alexian Village of Chattanooga	Current	01/01/1995	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1685C	Patient Transfer Agreement	Blount Memorial Hospital	Current	02/07/2001	Evergreen	Pediatric Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1714C	Patient Transfer Agreement	Columbia Indian Path Medical Center	Current	01/13/1997	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1715C	Patient Transfer Agreement	Columbia East Ridge Hospital	Current	03/31/1998	Evergreen	Pediatric Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1716C	Patient Transfer Agreement	East Ridge Hospital	Current	10/22/1996	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1717C	Patient Transfer Agreement	NovaMed Eye and Laser Surgery, Center of Chattanooga	Current	06/27/2002	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1750C	Patient Transfer Agreement	Jamestown Regional Medical Center, f/k/a Fentress County Hospital	Current	05/14/2012	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1753C	Patient Transfer Agreement	Cartersville Medical Center, LLC d/b/a Cartersville Medical Center	Current	05/21/2012	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1766C	Patient Transfer Agreement	Healthsouth Chattanooga Surgery Center	Current	04/13/1999	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.2377C	Patient Transfer Agreement	St Mary's Health System, Inc	Current	04/01/2003	Evergreen	Patient Transfer Agreement

Department	Organization Name	Contract Number	Contract Type	Vendor Other Party	Status	Effective Date	Expiration Date	Description
8028 - Patient Logistics	Erlanger Health System	2002.2531C	Patient Transfer Agreement	Memorial Healthcare System d/b/a Memorial Hospital and Memorial North Park Hospital	Current	02/01/2015	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.2697C	Patient Transfer Agreement	Redmond Regional Medical Center	Current	01/17/2012	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.2699C	Patient Transfer Agreement	Murray Medical Center	Current	12/05/2011	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.2700C	Patient Transfer Agreement	Medical Center of Manchester	Current	04/17/2015	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.2702C	Patient Transfer Agreement	Lincoln County Health System	Current	11/30/2011	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.2703C	Patient Transfer Agreement	Hamilton Medical Center	Current	11/22/2011	Evergreen	Patient Transfer
8028 - Patient Logistics	Erlanger Health System	2002.2704C	Patient Transfer Agreement	Fannin Regional Hospital	Current	06/18/2012	Evergreen	Patient Transfer
8028 - Patient Logistics	Erlanger Health System	2002.2706C	Patient Transfer Agreement	Cumberland Medical Center, Inc	Current	12/02/2011	Evergreen	Patient Transfer
8028 - Patient Logistics	Erlanger Health System	2002.2707C	Patient Transfer Agreement	Copper Basin Medical Center	Current	12/01/2011	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.2830C	Patient Transfer Agreement	Gordon Hospital	Current	07/01/2012	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.2854C	Patient Transfer Agreement	Chattanooga Rehabilitation Hospital	Current	07/25/2012	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.2891C	Patient Transfer Agreement	DeKalb Regional Medical Center, f/k/a Baptist DeKalb Hospital	Current	09/28/2008	09/27/2016	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.4049C	Patient Transfer Agreement	Vanderbilt University Medical Center	Current	07/01/2008	Evergreen	Burn Patient Transfer
8028 - Patient Logistics	Erlanger Health System	2002.4234C	Patient Transfer Agreement	Physicians Surgery Center of Chattanooga	Current	04/13/2015	04/12/2059	Patient Transfer
8028 - Patient Logistics	Erlanger Health System	2002.4267C	Patient Transfer Agreement	Parkridge Medical Center	Current	05/18/2012	Evergreen	Patient Transfer
8028 - Patient Logistics	Erlanger Health System	2002.4833C	Patient Transfer Agreement	Eye Surgery Center of Chattanooga	Current	10/23/2014	Evergreen	Patient Transfer

Department	Organization Name	Contract Number	Contract Type	Vendor Other Party	Status	Effective Date	Expiration Date	Description
8028 - Patient Logistics	Erlanger Health System	2002.5425C	Patient Transfer Agreement	Renaissance Surgery Center	Current	02/16/2012	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.6972C	Patient Transfer Agreement	Kidney Center of North Georgia	Current	05/18/2015	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.6973C	Patient Transfer Agreement	Kidney Center of Cleveland, LLC	Current	05/18/2015	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.6974C	Patient Transfer Agreement	Kidney Center of Missionary Ridge	Current	05/18/2015	Evergreen	Patient Transfer Agreement (Prior Agreements 2002.4023A)
8028 - Patient Logistics	Erlanger Health System	2002.6975C	Patient Transfer Agreement	Kidney Center of Highway 58	Current	05/18/2015	Evergreen	Patient Transfer Agreement (Prior Agreements 2002.4023A)
8028 - Patient Logistics	Erlanger Health System	2002.6976C	Patient Transfer Agreement	Chattanooga Kidney Center, LLC	Current	04/20/2015	Evergreen	Patient Transfer Agreement (Prior Agreements 2002.4023A)
8028 - Patient Logistics	Erlanger Health System	2002.6977C	Patient Transfer Agreement	Chattanooga Kidney Center North, LLC	Current	05/18/2015	Evergreen	Patient Transfer Agreement (Prior Agreements 2002.4023A)
8028 - Patient Logistics	Erlanger Health System	2002.707C	Patient Transfer Agreement	Kindred Hospital	Current	10/01/2001	Evergreen	Patient Transfer Agreement
8413 - Disaster Management & EOC	Erlanger Health System	2002.6387C	Patient Transfer Agreement	East Tennessee Regional Hospitals	Current	10/10/2014	Evergreen	Disaster Aid Agreement (Memorial Health Care; Parkridge Medical Center, Inc; Southern Tennessee Medical Center (Winchester & Sewanee); Copper Basin Medical Center; Star Regional Medical Center-(Athens & Etowah); Rhea Medical Center; Skyridge Medical Center)
							No. Of Contract:	**73**

Description	Section / Item
Erlanger Medical Center License	C-III-7-b
Erlanger Accreditation Letter	C-III-7-b
CMS Acceptance Letter	C-III-7-c
Erlanger State Licensure Survey Report	C-III-7-c

Board for Licensing Health Care Facilities

State of Tennessee

0000000140

No. of Beds 0788

DEPARTMENT OF HEALTH

This is to certify, that a license is hereby granted by the State Department of Health to

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY *to conduct and maintain a*

Hospital ERLANGER MEDICAL CENTER

Located at 975 EAST THIRD STREET, CHATTANOOGA

County of HAMILTON *, Tennessee.*

This license shall expire JUNE 04 *,* 2016 *, and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.*

In Witness Whereof, we have hereunto set our hand and seal of the State this 21ST *day of* MAY *,* 2015 *.*

In the Distinct Category(ies) of:
GENERAL HOSPITAL
PEDIATRIC CPRC HOSPITAL
TRAUMA CENTER LEVEL 1

By Vincent J. Davis, MPH
DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By
COMMISSIONER

DCF011

The Joint Commission

July 8, 2014

Re: #7809
CCN: #440104
Program: Hospital
Accreditation Expiration Date: April 05, 2017

Kevin M. Spiegel
President and CEO
Erlanger Health System
975 East Third Street
Chattanooga, Tennessee 37403

Dear Mr. Spiegel:

This letter confirms that your March 31, 2014 - April 04, 2014 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on June 20, 2014 and June 27, 2014 and the successful on-site Medicare Deficiency Follow-up event conducted on May 19, 2014, the areas of deficiency listed below have been removed. The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of April 05, 2014. We congratulate you on your effective resolution of these deficiencies.

§482.12 Governing Body
§482.41 Physical Environment
§482.42 Infection Control

The Joint Commission is also recommending your organization for continued Medicare certification effective April 05, 2014. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation applies to the following locations:

Academic Internal Medicine and Endocrinology
979 E. Third Street, Suite B-601, Chattanooga, TN, 37403

Academic Gastroenterology
979 East Third Street, Suite C-825, Chattanooga, TN, 37403

Academic Urologist at Erlanger
979 East Third Street, Suite C - 535, Chattanooga, TN, 37403

The Joint Commission

Alton Park (Southside) Community Health Center
100 East 37th Street, Chattanooga, TN, 37410

Dodson Avenue Community Health Center
1200 Dodson Avenue, Chattanooga, TN, 37406

Erlanger Academic Urologists
1755 Gunbarrel Road, Suite 209, Chattanooga, TN, 37421

Erlanger at Volkswagon Drive Wellness Center
7380 Volkswagon Drive, Suite 110, Chattanooga, TN, 37416

Erlanger East Family Practice
1755 Gunbarrel Road, Suite 201, Chattanooga, TN, 37421

Erlanger East Imaging
1751 Gunbarrel Road, Chattanooga, TN, 37421

Erlanger Health System - East Campus
1751 Gunbarrel Road, Chattanooga, TN, 37421

Erlanger Health System - Main Site
975 East Third Street, Chattanooga, TN, 37403

Erlanger Health System - North Campus
632 Morrison Springs Road, Chattanooga, TN, 37415

Erlanger Hypertension Management Center
979 East Third Street, Suite B601, Chattanooga, TN, 37403

Erlanger Metabolic and Bariatric Surgery Center
979 E. Third Street Suite C-620, Chattanooga, TN, 37403

Erlanger Neurology/Southeast Regional Stroke Center
979 East Third Street, Suite C830, Chattanooga, TN, 37403

Erlanger North Family Practice, Neurobehavioral & Memory Svs
632 Morrison Springs Road, Suite 202, Chattanooga, TN, 37415

Erlanger North Sleep Medicine and Neurology
632 Morrison Springs Road, Suite 300, Chattanooga, TN, 37415

Erlanger South Family Practice
60 Erlanger Drive, Suite A, Ringgold, GA, 30736

The Joint Commission

Erlanger Specialty Care for OB and Peds
1504 North Thornton Avenue, Suite 104, Dalton, GA, 30720

Hypertension Management - Chattanooga Lifestyle Center
325 Market Street, Suite 200, Chattanooga, TN, 37401

Life Style Center - Cardiac Rehab
325 Market Street, Chattanooga, TN, 37401

Ortho South
979 East Third Street suite C 430, Chattanooga, TN, 37403

Southern Orthopaedic Trauma Surgeons
979 East Third Street Suite C-225, Chattanooga, TN, 37403

TCT Cardiology/GI/Genetics
910 Blackford Street - 3rd Fl Massoud, Chattanooga, TN, 37403

TCT Children's Subspecialty Center
2700 West Side Drive, Cleveland, TN, 37312

TCT Endocrine
910 Blackford, 1st fl Massoud, Chattanooga, TN, 37403

TCT Hematology/Oncology
910 Blackford Street - 5th fl Massoud Bl, Chattanooga, TN, 37403

TCT Nephrology
910 Blackford St, Ground Level, TCTCH, Chattanooga, TN, 37403

University Health Obstetrics & Gynecology
979 East Third Street, Suite C-725, Chattanooga, TN, 37403

University Medical Assoc
960 East Third Street, Whitehall Building, Suite 208, Chattanooga, TN, 37403

University Orthopedics
979 East Third Street, Suite C-220, Chattanooga, TN, 37403

University Pediatrics
910 Blackford Street - Gr floor Massoud, Chattanooga, TN, 37403

University Pulmonary and Critical Care
979 East Third Street, Suite C 735, Chattanooga, TN, 37403

The Joint Commission

University Rheumatology Associates
979 East Third Street, Suite B-805, Chattanooga, TN, 37403

UT Dermatology
979 East Third Street, - Suite 425 A - Med Mall, Chattanooga, TN, 37403

UT Erlanger Cardiology
975 East Third Street, Suite C-520, Chattanooga, TN, 37403

UT Erlanger Cardiology East
1614 Gunbarrel Road, Ste 101, Chattanooga, TN, 37421

Ut Erlanger Health & Wellness@Signal Mtn
2600 Taft Highway, Signal Mountain, TN, 37377

UT Erlanger Lookout Mtn Primary Care
100 McFarland Road, Lookout Mountain, GA, 30750

UT Erlanger Primary and Athletic Health
1200 Pineville Road, Chattanooga, TN, 37405

UT Family Practice
1100 East Third Street, Chattanooga, TN, 37403

Workforce at UT Family Practice
1100 East 3rd Street, Chattanooga, TN, 37403

We direct your attention to some important Joint Commission policies. First, your Medicare report is publicly accessible as required by the Joint Commission's agreement with the Centers for Medicare and Medicaid Services. Second, Joint Commission policy requires that you inform us of any changes in the name or ownership of your organization, or health care services you provide.

Sincerely,

Mark Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services
CMS/Regional Office 4 /Survey and Certification Staff

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

CENTERS FOR MEDICARE & MEDICAID SERVICES
CONSORTIUM FOR QUALITY IMPROVEMENT
AND SURVEY & CERTIFICATION OPERATIONS

Reference M:2014.Erlanger.Med.Ctr.440104.Co.No.33779.11.18.14.accept.poc

December 8, 2014

Mr. Kevin Spiegel, CEO
Erlanger Health System
975 E. 3rd Street
Chattanooga, Tennessee 37403

RE: Erlanger Health System
CMS Certification Number (CCN) 44-0104
EMTALA Complaint Control Number: TN00033779

Dear Mr. Spiegel:

I am pleased to inform you that the plan of correction for *Erlanger Medical Center Hospital* has been reviewed and found to be acceptable.

When the Tennessee State Agency has determined that the noncompliance with EMTALA requirements has been corrected during their revisit, CMS will withdraw its current termination action. Failure to correct the deficient practice by February 16, 2014, will result in the termination of your Medicare provider agreement.

A copy of this letter is being forwarded to the Tennessee State Agency.

We thank you very much for your cooperation and look forward to working with you on a continuing basis in the administration of the Medicare program. Please contact our office if you have any questions and speak with Rosemary Wilder at 404-562-7452 or email: rosemary.wilder@cms.hhs.gov.

Sincerely yours,

Sandra M. Pace
Associate Regional Administrator

cc: North Carolina State Agency

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Final

PRINTED: 11/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440104	A. BUILDING _____ B. WING _____	C 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ERLANGER MEDICAL CENTER	975 E 3RD ST CHATTANOOGA, TN 37403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS On May 13, 2014, investigation of EMTALA complaint TN-33779 was completed. Erlanger Medical Center was found out of compliance with Requirements for the Responsibilities of Medicare Participating Hospitals in Emergency Cases 42 CRT Part 489.20 and 42 CFR 489.24. The administrator was notified via overnight mail on November 18, 2014 that a 90 day termination track would be imposed. The termination date is February 16, 2015.	A 000		
A2400	489.20(l) COMPLIANCE WITH 489.24 [The provider agrees,] in the case of a hospital as defined in §489.24(b), to comply with §489.24. This STANDARD is not met as evidenced by: Based on medical record review, review of facility policy, review of Medical Staff Rules and Regulations, and interview, the facility failed to provide appropriate transfers for four patients (#7, #8, #9, and #11). The findings included: Refer to A-2401 for failure to report receipt of an inappropriate transfer. Please refer to A-2402 for failure to conspicuously post signs. Please refer to A-2409 for failure to provide appropriate transfer.	A2400	A2400: 489.20(l) Compliance with 289.24 **The findings included:** This STANDARD is not met as evidenced by: based on Medical Record review, review of facility policy, review of medical staff rules and regulations, and interview, the facility failed to provide appropriate transfers for 4 patients (#7, #8, #9, and #11). **Plan of Correction Responsibility:** The Chief Medical Officer and the Chief of Emergency Medicine is responsible for the corrective action plan and ongoing compliance. **When/How Corrected:** See A2401 section and A2402 for corrective action plans. **Improvement to the Process** See A2401 section and A2402 for corrective action plans. **Education:** A2401 section and A2402 for corrective action plans.	
A2401	489.20(m) RECEIVING AN INAPPROPRIATE TRANSFER [The provider agrees,] in the case of a hospital as	A2401		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jan Kay, CNE | TITLE: Chief Nurse Executive | (X6) DATE: 12/4/14

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ner safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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A2401	Continued From page 1 defined in §489.24(b), to report to CMS or the State survey agency any time it has reason to believe it may have received an individual who has been transferred in an unstable emergency medical condition from another hospital in violation of the requirements of §489.24(e). This STANDARD is not met as evidenced by: Based on review of facility policy, medical record review, and interview, the facility failed to report receipt of a patient transferred in an unstable emergency medical condition from the facility's East campus (Hospital #1) to the hospital's primary location (main campus - Hospital #2), a distance of 10.2 miles, for one patient (#7) of sixteen patients reviewed. The findings included: Review of facility policy titled "Transfers...PC.074" most recently revised in February, 2012, revealed, "...To establish guidelines for transferring patient within a facility, to an alternative level of care, or to another acute care facility while assuring medically appropriate continuity of care and compliance with EMTALA (Emergency Medical Treatment and Active Labor Act) regulation...The transferring physician determines the method of patient transport and the amount of support that will be needed during transport..." Review of a policy titled "(Facility) East Emergency Services Scope of Services" revealed, "Origination Date: 3/14" and the approval date was blank, indicating it had not been approved by the Medical Staff or the Governing Body.	A2401	A2401: 489.20(m) Receiving an Inappropriate Transfer **The findings included:** This STANDARD is not met as evidenced by: based on Medical Record review, review of facility policy, and interview, the facility failed to report receipt of a patient transferred in an unstable emergency medical condition from the facility Erlanger East Campus (Hospital #1) to the Hospitals' primary location (Main Campus- Hospital #2), a distance of 10.2 miles, for one patient #7 of 16 patients reviewed. **Plan of Correction Responsibility:** The Chief Medical Officer and the Chief of Emergency Medicine is responsible for the corrective action plan and ongoing compliance. **When/How Corrected:** Hospital # 1 is within the Erlanger Health System; however this was not reflected in the EMTALA Transfer Policy and **is now reflected in the policy draft. A new** system wide policy was developed to reflect this language and inclusion of current EMTALA and associated State law. The draft of this policy was reviewed by the Medical Executive Committee on December 1, 2014. The committee reviewed the policy and requested additional information. The final draft will be approved by the Medical Executive Committee on January 5, 2015. (See attachment # 1 - Draft EMTALA Transfer Policy) (See attachment # 7 – Medical Staff Executive Committee Meeting Agenda)	12/1/2014 1/5/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A2401	Continued From page 2 Review of facility policy for the hospital's main campus titled "Emergency Department Scope of Services Number: EMS.280" most recently revised in March, 2010, revealed, "...An Emergency Medical Condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of prompt and appropriate medical attention could result in...placing the health or safety of the patient or unborn child in serious jeopardy...The following conditions are declared to be emergency conditions by statute and regulation ...pregnancy with contractions present...Evaluation, management, and treatment of patients is appropriate and expedient...Immediate evaluation and stabilization, to the degree reasonably possible, will be available for each patient who presents with an emergency medical condition...Patients are to be transported to the nearest appropriate ED (emergency department) in accordance with applicable laws, regulations, and guidelines...All transfers will comply with local, state, and federal laws..." Review of an Emergency Room Log dated April 2, 2014, revealed Patient #7 presented to the facility's East campus with complaint of Vaginal Bleeding. Medical record review of a Triage note dated April 2, 2014, revealed, "...(6:37 a.m.) Complaint: Vaginal bleeding...(6:49 a.m.) Pain level 9 (0-10)...Quality is cramping. Since yesterday...states...is a 'couple weeks pregnant'...had a miscarriage in Jan (January) LMP (Last Menstrual Period): 11-15-2013 (history of five pregnancies, three delivered pregnancies)..."	A2401	**The Emergency Services Scope of Services policies (EMS #280 and EEED #7174.100) were reviewed and approved to include documentation of approval by the Chief of Emergency Medicine, and revision of the staffing model for Erlanger Baroness Campus. These policies are departmental policies that are required by all departments explaining the scope of the services the department provides, staffing for the department, special equipment and procedures.** **(See attachment #2 and #10.)**	11/24/2014
			A new transfer form was developed and was approved by the Health Information Management Forms Committee on 11/24/14. It was sent to the Print Shop for print and will be ready for distribution by 12/5/2014. (See attachment #4)	12/5/2014
			Education: **Education will be provided to all emergency staff on the new policy updates (EMTALA Transfer policy, EMTALA-Provision of On Call Coverage Policy , the new EMTALA Transfer Form and the education al power point presentation). This mandatory education will be distributed in notebooks to each Emergency Departments in the Erlanger Health System. All emergency department staff including physician and physician extenders will be required to read and acknowledge by signature understanding of the new policies and processes by December 31, 2014.**	12/31/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A2401	Continued From page 3 Medical record review of a history and physical dated April 2, 2014, at 7:14 a.m., revealed, "pt (patient) w/ (with) abd (abdominal) pain. lmp (last mentrual period) 11/5/13. thought she had miscarriage in January due to heavy bleeding and passing tissue. Was told last week that she is pregnant again. now having severe cramps. had some light bleeding past 2 days. today no bleeding but severe cramps. vomit x (times) 2. no diarrhea. no urinary sx (symptoms). no fever...Sudden onset of symptoms, Symptoms are worsening, are constant. Maximum severity of symptoms severe, Currently symptoms are severe. In my professional medical judgment...this patient presents with an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that in the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily function, or serious dysfunction of a body organ...(7:18 a.m.) Abdominal exam included findings of abdomen tender, to the left upper quadrant, to the left lower quadrant, to the right lower quadrant, moderate intensity, no distension, firm uterus at umbilicus...Medical History...miscarriage x 2...cesarean section..." Medical record review of a physician's progress note dated April 2, 2014, at 7:20 a.m., revealed, "...BSUS (Bedside Ultrasound) shows IUP (Intrauterine Pregnancy) at approx 20 wks (approximately 20 weeks). Will obtain formal us (ultrasound), labs, and ob (obstetric) consult..." Medical record review of the Nursing Assessment: Continuing Assessment dated April	A2401	**Monitoring of the Corrective Action Process:** 1. Monitoring will be conducted monthly for 4 continuous months beginning January 2015- April 2015 **by the Emergency Department Nurse Manager at Erlanger East**. A review of 70 cases per month will be randomly selected to assess for compliance of appropriate completion of the new EMTALA Transfer Form with a minimum of 90% compliance rate. If this is not met after 4 months of review, the review of records will be continued for an additional 4 months until 90% compliance is achieved, Results will be reported to the Erlanger Health System Quality Oversight Committee.	1/2015-4/1015

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A2401	Continued From page 4 2, 2014, revealed, "...(7:24 a.m.) per pt she miscarried in January at home and was never seen by OBGYN (Obstetrician/Gynecologist) to confirm. Pt sts (states) she was seen by OBGYN recently, but could not give specific day or date, and was told her blood pregnancy test was positive. Pt sts she is 'a couple of weeks pregnant'...patient appears, restless, uncomfortable...(7:40 a.m.) pt rates pain 8 on a scale of 1-10. MD notified new medication order received...(8:12 a.m.) States worsening pain, pt still c/o pain an 8 on a scale of 1-10. MD notified and new medication order received...Patient appears restless, uncomfortable...(8:56 a.m.) States decreased pain, Patient states decreased pain, although she still rates it 7 out of 10. She is not as restless and seems in no pain distress at this time. pain is more intermittent at this time... (9:10 a.m.) States worsening pain...Patient appears, uncomfortable..." Medical record review of a physician's note dated April 2, 2014, at 8:53 a.m., revealed, "Diagnosis Final: Primary Preterm Labor." Medical record review of a nurse's note dated April 2, 2014, at 8:54 a.m., revealed, "Ambulance service contacted...Estimated time of arrival 15-20 min (minutes)." Medical record review of a nurse's note dated April 2, 2014, at 9:06 a.m., revealed, "Indocin (medication to delay labor) ordered by (Medical Doctor - M.D. #1). Pharmacy called and we do not carry that medication on this campus. MD (MD #1) aware, medication order canceled." Medical record review of a nurse's note dated April 2, 2014, at 9:14 a.m., revealed, "Transfer:	A2401	**Indocin is now stocked at the Erlanger East campus pharmacy and available – Indomethacin dosage = 25mg x2 (50mg) PO stat then 25mg PO every 6 hours. Magnesium and Terbutaline are also available if requested.**	12/5/2014

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A2401	Continued From page 5 Reason for transfer need for specialized care, Diagnosis: preterm labor, Accepting Institution: (Hospital #2) Labor and Delivery, Accepting physician (M.D. #2)...Report called to receiving facility..." Medical record review of a Transfer Authorization dated April 2, 2014, at 9:18 a.m., revealed, "STABILITY The patient is stabilized at the time of transfer and no medical deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from this facility, or, with respect to a pregnant woman having contractions, the woman has delivered (including the placenta) OR The Patient is in a state of an emergency medical condition, and I hereby certify that based upon the information available to me at this time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility, outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer..." Review of the Transfer Authorization revealed both statements were checked. Further review revealed, "...appropriate transport service...Advanced...The receiving facility has agreed to accept the patient...Facility (Hospital #2)...accepting physician (M.D. #2)..." Continued review revealed, "...Reason for transfer: preterm labor Risk of transfer: death by MVC (motor vehicle crash) Benefits of transfer: higher level of care..." Medical record review of a physician's progress note dated April 2, 2014, at 9:22 a.m., revealed, "formal us (ultrasound) shows (20 week intrauterine pregnancy) and incompetent cervix. Discussed results (with M.D. #2 - patient's	A2401	**Indocin is now stocked at the Erlanger East campus pharmacy and available – Indomethacin dosage = 25mg x2 (50mg) PO stat then 25mg PO every 6 hours. Magnesium and Terbutaline are also available if requested.** 12/5/2014 Hospital # 1 is within the Erlanger Health System; however this was not reflected in the EMTALA Transfer Policy and **is now reflected in the policy draft. A new** system wide policy was developed to reflect this language and inclusion of current EMTALA and associated State law. The draft of this policy was reviewed by the Medical Executive Committee on December 1, 2014. The committee reviewed the policy and requested additional information. The final draft will be approved by the Medical Executive Committee on January 5, 2015. 12/1/2014 1/5/2015 (See attachment # 1 - Draft EMTALA Transfer Policy) (See attachment # 7 – Medical Staff Executive Committee Meeting Agenda)	

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A2401	Continued From page 6 obstetrician)...who rec (recommended) indomethacin (Indocin) but med (medication) unavailable here at east. due to early pregnancy pt (patient) will go emergency transport to (Hospital #2) L/D (Labor and Delivery) for OB (Obstetrician) eval (evaluation)." Medical record review of a nurse's note dated April 2, 2014, at 9:27 a.m., revealed, "Disposition: (Hospital #2) Transport: Ambulance, Patient left the department." Medical record review revealed OB did not see the patient in the ED and was not notified of Indocin being unavailable. Further medical record review revealed no documentation regarding a pelvic examination, fetal heart tones being monitored, or obtaining timing of any contractions. Review of an EMS (Emergency Medical Service) Patient Care Report dated April 2, 2014, revealed, "...Level of Care: ALS (Advanced Life Support)...At patient (9:15 a.m.)...Transport: (9:25 a.m.) At dest (destination): (9:43 a.m.)...Narrative: Dispatched emer (emergent) to (Facility) to transfer pt (patient) to (Hospital #2)...pt in premature labor...nurse advised '...they performed an ultrasound and the cervix was not even visible so they called for transfer...have given her 1 liter NS (normal saline), 8 mg (milligrams) Morphine, 0.5 Dilaudid, and 4 mg of Zofran. Pt has had no pain relief.' Further ALS asses (assessment) revealed pt was having contractions at 1-2 min's (minutes) apart, pt was hot on a fetal heart rate monitor, and had no Tocolytics (medication to slow contractions) on board...continued to have contractions at 1-2 mins part, right before arrival at (Hospital #2) pt	A2401	**Review of the medical record of patient # 7 will be formally reviewed by the Chief of Emergency Medicine on 12/9/2014. Based on this case new guidelines for management of obstetric patients in the Erlanger East Emergency Department has been developed and approved by the Chief of Emergency Medicine/Erlanger East Medical Director on 12/3/2014. (See attachment #11)**	12/9/2014

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A2401	Continued From page 7 stated she felt like something was coming out. Upon initial evaluation nothing was seen, but then her water broke and both the baby's feet presented toes pointing upward...pt could not push anymore, the feet were purple had no movement. By this time we were at (Hospital #2) and diverted straight to the ER (Emergency Room). Moved pt to bed...staff started to deliver baby. When baby was fully delivered it was lifeless and staff did not attempt resuscitation...pt could not sign due to staff rushing her to L&D..." Medical record review of Hospital #2's ER record dated April 2, 2014, revealed, "Complaint: 21 week ob breech presentation Triage Time...(9:47 a.m.)...Pain: 10 (0-10)...brought in by...ems (emergency medical service), transfer from (facility)...feet of fetus are visible (9:49 a.m.)...Medications prior to arrival, morphine...8 mg (milligrams), dilaudid...0.5 mg...zofran 4 mg." Medical record review of an ultrasound report dated April 2, 2014, at 9:00 a.m. (performed at the facility before transfer), revealed, "...Results: A viable intrauterine pregnancy is identified, estimated gestational age 20 weeks and 2 days. The heart rate...measures 136 beats per minute. Of note the cervical canal is poorly identified, and the cervical os appears to be abnormally dilated up to 4.2 cm (centimeters)...findings compatible with incompetent cervix. GYN (Gynecology) assessment recommended." Medical record review of a Newborn Identification record dated April 2, 2014, revealed, "...Infant's Birth Date April 2, 2014, at (9:50 a.m.) Sex male...Weight 364 gm (grams) Length 26 cms (centimeters)..."	A2401		

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A2401	Continued From page 8 Medical record review of a physician's progress note dated April 2, 2014, at 9:59 a.m., revealed, "...NICU (neo-natal intensive care unit) and OB paged directly on arrival. Pt preterm did not know...was pregnant. Did not go into labor/contractions...Fetus blue/red on arrival. Fetus delivered, non-viable with OB assistance in ED (emergency department). Cord clamped...Pt transported to L+D (labor and delivery) for placental." Medical record review of a history and physical dated April 2, 2014, revealed, "...(10:02 a.m.) Chief Complaint: arrives c/o (complains of) labor. Breech presentation noted...Did not know she was pregnant. 21 weeks by LMP. NO prenatal care...Pain controlled. Fetus non viable. No alleviating or aggrevating (aggravating) factors. Pain cramping to lower abd (abdomen). No sig (significant) bleeding...In my professional medical judgment...this patient presents with an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily function, or serious dysfunction of a body organ or part...reports vaginal bleeding, vaginal discharge...Pelvic: Bimanual exam abnormal, Cervix dilated 2 cm (centimeters), fetus in breech presentation, legs at introitus on arrival..." Medical record review of a physician's progress note dated April 2, 2014, at 10:57 a.m., revealed, "Precipitous Delivery...OB notified of patients arrival to the emergency department. Infant delivered via vaginal delivery, at (9:50 a.m.)...Initial APGAR score...3 (0-10, higher score	A2401		

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A2401	Continued From page 9 indicative of better clinical condition) Patient tolerated the procedure with difficulty..." Medical record review of a physician's progress note dated April 2, 2014, at 11:00 a.m., revealed, "...OB Called to ER for delivery of preterm with no prenatal care...had presented to (facility) with abd pain and cramps...transferred to ER here where she delivered non-viable male infant...Placenta remains intact..." Medical record review of a Bereavement Loss Checklist L&D dated April 2, 2014, revealed, "...Complications this pregnancy: Preterm labor Obstetrician: (M.D. #2) Delivery Date/Time: 4-2-14 at (9:50 a.m.) Death date/Time: 4-2-14 at (9:50 a.m.)...Sex: M (male)..." Medical record review revealed, "...04/02/2014 (9:26 p.m.)...Delivery Time: Placenta - Manual." Medical record review revealed the patient was discharged on April 2, 2014. Interview with the Corporate Preparedness/Safety Officer on May 9, 2014, at 2:40 p.m., in a conference room, revealed the facility did not have current approved EMTALA policies for Hospital #1 except for a transfer policy. Further interview confirmed the unapproved policy with an origination date of March 2014 was under review. Interview with the ER Nurse Manager on May 12, 2014, at 10:20 a.m., in a conference room, revealed the facility had provided labor and delivery services since 1996, delivered infants of 35-36 weeks gestation through full term, had the capability of providing monitoring of fetal heart tones in the ED, and had OB on call. She stated,	A2401		

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A2401	Continued From page 10 "...unless high risk, and under EMTALA we just deliver, pray for the best, and after delivery transport downtown (Hospital #2)." Interview with the ED's Medical Director on May 12, 2014, at 11:58 a.m., in a conference room, and in the presence of the facility's Corporate Preparedness/Safety Officer, revealed Patient #7 presented to Hospital #2 and he delivered Patient #7's Infant. Continued interview confirmed the facility's East campus inappropriately transferred Patient #7 on April 2, 2014, and confirmed Patient #7 was transferred to Hospital #2 in an unstable medical condition. He stated, "...When patient arrived, I didn't have time to read her paperwork. The feet were already out and we had to deliver."	A2401		
A2402	489.20(q) POSTING OF SIGNS [The provider agrees,] In the case of a hospital as defined in §489.24(b), to post conspicuously in any emergency department or in a place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment in areas other than traditional emergency departments (that is, entrance, admitting area, waiting room, treatment area) a sign (in a form specified by the Secretary) specifying the rights of individuals under section 1867 of the Act with respect to examination and treatment for emergency medical conditions and women in labor; and to post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital or rural primary care hospital (e.g., critical access hospital) participates in the Medicaid program under a State plan approved under Title XIX.	A2402	A2402: 489.24(q) POSTING OF SIGNS **The findings included:** This STANDARD is not met as evidenced the facility failed to conspicuously post the required signs with respect to the right to examination and treatment for emergency medical conditions and women in labor. **Plan of Correction Responsibility:** The Medical Director for Emergency Services has the responsibility for the plan of correction.	

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A2402	Continued From page 11 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to conspicuously post the required signs with respect to the right to examination and treatment for emergency medical conditions and women in labor. The findings included: Observation of the facility's Emergency Room (ER) with a Nurse Manager on May 9, 2014, at 10:20 a.m., revealed the required signs were not posted in the patient/family waiting area of the ER. (Required signs inform patients of the right to receive an appropriate medical screening examination, necessary stabilizing treatment, and if necessary an appropriate transfer if the patient has a medical emergency, regardless of ability to pay, and if the facility does/does not participate in the Medicaid program.) Interview with a Nurse Manager on May 9, 2014, at approximately 10:30 a.m., in the outpatient surgery entrance, confirmed the facility failed to conspicuously post the required signs.	A2402	**When/How Corrected:** The signage was partially blocked at the Erlanger East Emergency Room entrance by the vending machines and no signage was posted at the desk inside the Emergency Department registration/information counter. 1. The vending machines were moved in order to have total view of the required signage at the Erlanger East Emergency Department entrance. Corrected during survey 5/12/2014 2. The required signage was posted behind the Erlanger East Emergency Department registration/information counter in the waiting room. Corrected during Survey 5/21/2014 3. The required signage was posted at the Erlanger East Ambulatory Entrance (Attachments #8 – photos of posted required signage)	5/12/2014 5/12/2014 11/24/2014
A2409	489.24(e)(1)-(2) APPROPRIATE TRANSFER (1) General If an individual at a hospital has an emergency medical condition that has not been stabilized (as defined in paragraph (b) of this section), the hospital may not transfer the individual unless - (i) The transfer is an appropriate transfer (within the meaning of paragraph (e)(2) of this section); and (ii)(A) The individual (or a legally responsible person acting on the individual's behalf) requests the transfer, after being informed of the hospital's	A2409		

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A2409	Continued From page 12 obligations under this section and of the risk of transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer. (B) A physician (within the meaning of section 1861(r)(1) of the Act) has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based; or (C) If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its bylaws or rules and regulations) has signed a certification described in paragraph (e)(1)(ii)(B) of this section after a physician (as defined in section 1861(r)(1) of the Act) in consultation with the qualified medical person, agrees with the certification and subsequently countersigns the certification. The certification must contain a summary of the risks and benefits upon which it is based. (2) A transfer to another medical facility will be appropriate only in those cases in which - (i) The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;	A2409		

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A2409	Continued From page 13 (ii) The receiving facility (A) Has available space and qualified personnel for the treatment of the individual; and (B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment. (iii) The transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer, including available history, records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) required under paragraph (e)(1)(ii) of this section, and the name and address of any on-call physician (described in paragraph (g) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records (e.g., test results not yet available or historical records not readily available from the hospital's files) must be sent as soon as practicable after transfer; and (iv) The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer. This STANDARD is not met as evidenced by: Based on review of facility policy, review of Rules and Regulations of the Medical Staff, review of Emergency Room Logs, medical record review, and interview, the facility failed to appropriately	A2409	A2409: 489.24(e)(1)-(2) Appropriate Transfers **The findings included:** This STANDARD is not met as evidenced by: Based on review of facility policy, review of Rules and Regulations of the Medical Staff, review of Emergency Room Logs, medical record review, and interview, the facility failed to appropriately transfer four patients (#7, #8, #9, and #11) of the 16 patients reviewed. **Plan of Correction Responsibility:** The Chief Medical Officer and the Chief of Emergency Medicine is responsible for the corrective action plan and ongoing compliance.	

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A2409	Continued From page 14 transfer four patients (#7, #8, #9, and #11) of sixteen patients reviewed. The findings included: Review of facility policy titled "Transfers...PC.074" most recently revised in February, 2012, revealed, "...To establish guidelines for transferring patient within a facility, to an alternative level of care, or to another acute care facility while assuring medically appropriate continuity of care and compliance with EMTALA (Emergency Medical Treatment and Active Labor Act) regulation...The following information must be completed prior to a transfer...transferring physician must obtain acceptance from a receiving physician...receiving facility must accept the patient...patient and/or family members consent...Copies of the completed Emergency Department (ED) record, lab results/x-rays and EKG reports will be sent with patient...Transfer form completed. The transferring physician determines the method of patient transport and the amount of support that will be needed during transport. The transferring physician also maintains responsibility for care during transport until arrival at the receiving facility..." Review of a policy titled "(Facility) East Emergency Services Scope of Services" revealed, "Origination Date: 3/14" and the approval date was blank, indicating it had not been approved by the Medical Staff or the Governing Body. Review of facility policy for the hospital's main campus titled "Emergency Department Scope of Services Number: EMS.280" most recently revised in March, 2010, revealed, "...An	A2409	**When/How Corrected:** Hospital # 1 is within the Erlanger Health System; however this was not reflected in the EMTALA Transfer Policy and **is now reflected in the policy draft.** A new system wide policy was developed to reflect this language and inclusion of current EMTALA and associated State law. The draft of this policy was reviewed by the Medical Executive Committee on December 1, 2014. The committee reviewed the policy and requested additional information. The final draft will be approved by the Medical Executive Committee on January 5, 2015. (See attachment # 1 - Draft EMTALA Transfer Policy) (See attachment # 7 – Medical Staff Executive Committee Meeting Agenda) **The Emergency Services Scope of Services policies (EMS #280 and EEED #7174.100) were reviewed and approved to include documentation of approval by the Chief of Emergency Medicine, and revision of the staffing model for Erlanger Baroness Campus. These policies are departmental policies that are required by all departments explaining the scope of the services the department provides, staffing for the department, special equipment and procedures.** **(See attachment #2 and #10.)**	12/1/2014 12/5/2014 11/24/2014

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A2409	Continued From page 15 Emergency Medical Condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of prompt and appropriate medical attention could result in...placing the health or safety of the patient or unborn child in serious jeopardy...The following conditions are declared to be emergency conditions by statute and regulation ...pregnancy with contractions present...acute pain rising to the level of the general definition of emergency medical condition...Evaluation, management, and treatment of patients is appropriate and expedient...Immediate evaluation and stabilization, to the degree reasonably possible, will be available for each patient who presents with an emergency medical condition...Necessary equipment...supplies must be immediately available in the facility at all times...Necessary drugs and agents must be immediately available in the facility at all times...Patients are to be transported to the nearest appropriate ED (emergency department) in accordance with applicable laws, regulations, and guidelines...All transfers will comply with local, state, and federal laws...Equipment and Supplies...Radiological, Imaging and Diagnostic Services Available 24/7 (24 hours per day/7 days per week)...fetal monitoring..." Review of Rules and Regulations of the Medical Staff revealed, "...Effective date: December 7, 1995...A phone call from the requesting physician to the consultant is required for emergent/urgent consults to ensure clear communication regarding the clinical situation and timely coordination of care...The need for consultation will be determined by the (ED) physician...A satisfactory consultation includes examination of	A2409		

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A2409	Continued From page 16 the patient and the record. A written or dictated opinion signed by the consultant must be included in the medical record. For emergent/urgent situations, the consulting physician should discuss findings directly with the referring physician in addition to the written documentation...Medical records contain...Emergency care, treatment, and services provided to the patient before his or her arrival, if any...Documentation and findings of assessments...Conclusion or impressions drawn from medical history and physical examination...Progress notes made by authorized individuals...Consultation reports...All medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided..." Review of an Emergency Room Log dated April 2, 2014, revealed Patient #7 presented to the facility's East campus with complaint of Vaginal Bleeding. Medical record review of a Triage note dated April 2, 2014, revealed, "...(6:37 a.m.) Complaint: Vaginal bleeding...(6:49 a.m.) Pain level 9 (0-10)...Quality is cramping. Since yesterday...states...Is a 'couple weeks pregnant'...had a miscarriage in Jan (January) LMP (Last Menstrual Period): 11-15-2013 (history of five pregnancies, three delivered pregnancies)..." Medical record review of a history and physical dated April 2, 2014, at 7:14 a.m., revealed, "pt (patient) w/ (with) abd (abdominal) pain. lmp (last mentrual period) 11/5/13. thought she had miscarriage in January due to heavy bleeding and	A2409		

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A2409	Continued From page 17 passing tissue. Was told last week that she is pregnant again, now having severe cramps, had some light bleeding past 2 days, today no bleeding but severe cramps, vomit x (times) 2, no diarrhea, no urinary sx (symptoms), no fever...Sudden onset of symptoms, Symptoms are worsening, are constant. Maximum severity of symptoms severe, Currently symptoms are severe. In my professional medical judgment...this patient presents with an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that in the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily function, or serious dysfunction of a body organ...(7:18 a.m.) Abdominal exam included findings of abdomen tender, to the left upper quadrant, to the left lower quadrant, to the right lower quadrant, moderate intensity, no distension, firm uterus at umbilicus...Medical History...miscarriage x 2...cesarean section..." Medical record review of a physician's progress note dated April 2, 2014, at 7:20 a.m., revealed, "...BSUS (Bedside Ultrasound) shows IUP (Intrauterine Pregnancy) at approx 20 wks (approximately 20 weeks). Will obtain formal us (ultrasound), labs, and ob (obstetric) consult..." Medical record review of the Nursing Assessment: Continuing Assessment dated April 2, 2014, revealed, "...(7:24 a.m.) per pt she miscarried in January at home and was never seen by OBGYN (Obstetrician/Gynecologist) to confirm. Pt sts (states) she was seen by OBGYN recently, but could not give specific day or date, and was told her blood pregnancy test was	A2409		

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A2409	Continued From page 18 positive. Pt sts she is 'a couple of weeks pregnant'...patient appears, restless, uncomfortable...(7:40 a.m.) pt rates pain 8 on a scale of 1-10. MD notified new medication order received...(8:12 a.m.) States worsening pain, pt still c/o pain an 8 on a scale of 1-10. MD notified and new medication order received...Patient appears restless, uncomfortable...(8:56 a.m.) States decreased pain, Patient states decreased pain, although she still rates it 7 out of 10. She is not as restless and seems in no pain distress at this time. pain is more intermittent at this time... (9:10 a.m.) States worsening pain...Patient appears, uncomfortable..." Medical record review of a physician's note dated April 2, 2014, at 8:53 a.m., revealed, "Diagnosis Final: Primary Preterm Labor." Medical record review of a nurse's note dated April 2, 2014, at 8:54 a.m., revealed, "Ambulance service contacted...Estimated time of arrival 15-20 min (minutes)." Medical record review of a nurse's note dated April 2, 2014, at 9:06 a.m., revealed, "Indocin (medication to delay labor) ordered by (Medical Doctor - M.D.,#1). Pharmacy called and we do not carry that medication on this campus. MD (MD #1) aware, medication order canceled." Medical record review of a nurse's note dated April 2, 2014, at 9:14 a.m., revealed, "Transfer: Reason for transfer need for specialized care, Diagnosis: preterm labor, Accepting Institution: (Hospital #2) Labor and Delivery, Accepting physician (M.D. #2)...Report called to receiving facility..."	A2409	**Indocin is now stocked at the Erlanger East campus pharmacy and available – Indomethacin dosage = 25mg x2 (50mg) PO stat then 25mg PO every 6 hours. Magnesium and Terbutaline are also available if requested.**	12/5/2014

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A2409	Continued From page 19 Medical record review of a Transfer Authorization dated April 2, 2014, at 9:18 a.m., revealed, "STABILITY The patient is stabilized at the time of transfer and no medical deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from this facility, or, with respect to a pregnant woman having contractions, the woman has delivered (including the placenta) OR The Patient is in a state of an emergency medical condition, and I hereby certify that based upon the information available to me at this time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility, outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer..." Review of the Transfer Authorization revealed both statements were checked. Further review revealed, "...appropriate transport service...Advanced...The receiving facility has agreed to accept the patient...Facility (Hospital #2)...accepting physician (M.D. #2)..." Continued review revealed, "...Reason for transfer: preterm labor Risk of transfer: death by MVC (motor vehicle crash) Benefits of transfer: higher level of care..." Medical record review of a physician's progress note dated April 2, 2014, at 9:22 a.m., revealed, "formal us (ultrasound) shows (20 week intrauterine pregnancy) and incompetent cervix. Discussed results (with M.D. #2 - patient's obstetrician)...who rec (recommended) indomethacin (Indocin) but med (medication) unavailable here at east. due to early pregnancy pt (patient) will go emergency transport to (Hospital #2) L/D (Labor and Delivery) for OB (Obstetrician) eval (evaluation)."	A2409	Transfer Authorization form revealed it had been completed inappropriately. It revealed both statements were checked (stable or state of emergency medical condition). A new transfer form was developed and was approved by the Health Information Management Forms Committee on 11/24/14. It was sent to the Print Shop for print and will be ready for distribution by 12/5/2014. **Education:** **Education will be provided to all emergency staff on the new policy updates (EMTALA Transfer policy, EMTALA-Provision of On Call Coverage Policy , the new EMTALA Transfer Form and the education al power point presentation). This mandatory education will be distributed in notebooks to each Emergency Departments in the Erlanger Health System. All emergency department staff including physician and physician extenders will be required to read and acknowledge by signature understanding of the new policies and processes by December 31, 2014.**	11/24/2014 12/5/2014 12/31/2014

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A2409	Continued From page 20 Medical record review of a nurse's note dated April 2, 2014, at 9:27 a.m., revealed, "Disposition: (Hospital #2) Transport: Ambulance, Patient left the department." Medical record review revealed OB did not see the patient in the ED and was not notified of Indocin being unavailable. Further medical record review revealed no documentation regarding a pelvic examination, fetal heart tones being monitored, or obtaining timing of any contractions. Review of an EMS (Emergency Medical Service) Patient Care Report dated April 2, 2014, revealed, "...Level of Care: ALS (Advanced Life Support)...At patient (9:15 a.m.)...Transport: (9:25 a.m.) At dest (destination): (9:43 a.m.)...Narrative: Dispatched emer (emergent) to (Facility) to transfer pt (patient) to (Hospital #2)...pt in premature labor...nurse advised '...they performed an ultrasound and the cervix was not even visible so they called for transfer...have given her 1 liter NS (normal saline), 8 mg (milligrams) Morphine, 0.5 Dilaudid, and 4 mg of Zofran. Pt has had no pain relief.' Further ALS asses (assessment) revealed pt was having contractions at 1-2 min's (minutes) apart, pt was not on a fetal heart rate monitor, and had no Tocolytics (medication to slow contractions) on board...continued to have contractions at 1-2 mins part, right before arrival at (Hospital #2) pt stated she felt like something was coming out. Upon initial evaluation nothing was seen, but then her water broke and both the baby's feet presented toes pointing upward...pt could not push anymore, the feet were purple had no movement. By this time we were at (Hospital #2)	A2409	**Monitoring of the Corrective Action Process:** 1. Monitoring will be conducted monthly for 4 continuous months beginning January 2015- April 2015 **by the Emergency Department Nurse Manager at Erlanger East.** A review of 70 cases per month will be randomly selected to assess for compliance of appropriate completion of the new EMTALA Transfer Form with a minimum of 90% compliance rate. If this is not met after 4 months of review, the review of records will be continued for an additional 4 months until 90% compliance is achieved. Results will be reported to the Erlanger Health System Quality Oversight Committee. **Review of the medical record of patient # 7 will be formally reviewed by the Chief of Emergency Medicine on 12/9/2014. Based on this case new guidelines for management of obstetric patients in the Erlanger East Emergency Department has been developed and approved by the Chief of Emergency Medicine/Erlanger East Medical Director on 12/3/2014. (See attachment #11)**	1/2015-4/1015 12/9/2014 12/3/2014

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A2409	Continued From page 21 and diverted straight to the ER (Emergency Room). Moved pt to bed...staff started to deliver baby. When baby was fully delivered it was lifeless and staff did not attempt resuscitation...pt could not sign due to staff rushing her to L&D..." Medical record review of Hospital #2's ER record dated April 2, 2014, revealed, "Complaint: 21 week ob breech presentation Triage Time...(9:47 a.m.)...Pain: 10 (0-10)...brought in by...ems (emergency medical service), transfer from (facility)...feet of fetus are visible (9:49 a.m.)...Medications prior to arrival, morphine...8 mg (millgrams), dilaudid...0.5 mg...zofran 4 mg." Medical record review of an ultrasound report dated April 2, 2014, at 9:00 a.m. (performed at the facility before transfer), revealed, "...Results: A viable intrauterine pregnancy is identified, estimated gestational age 20 weeks and 2 days. The heart rate...measures 136 beats per minute. Of note the cervical canal is poorly identified, and the cervical os appears to be abnormally dilated up to 4.2 cm (centimeters)...findings compatible with incompetent cervix. GYN (Gynecology) assessment recommended." Medical record review of a Newborn Identification record dated April 2, 2014, revealed, "...Infant's Birth Date April 2, 2014, at (9:50 a.m.) Sex male...Weight 364 gm (grams) Length 26 cms (centimeters)..." Medical record review of a physician's progress note dated April 2, 2014, at 9:59 a.m., revealed, "...NICU (neo-natal intensive care unit) and OB paged directly on arrival. Pt preterm did not know...was pregnant. Did not go into labor/contractions...Fetus blue/red on arrival.	A2409		

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A2409	Continued From page 22 Fetus delivered, non-viable with OB assistance in ED (emergency department). Cord clamped...Pt transported to L+D (labor and delivery) for placental." Medical record review of a history and physical dated April 2, 2014, revealed, "...(10:02 a.m.) Chief Complaint: arrives c/o (complains of) labor. Breech presentation noted...Did not know she was pregnant. 21 weeks by LMP. NO prenatal care...Pain controlled. Fetus non viable. No alleviating or aggrevating (aggravating) factors. Pain cramping to lower abd (abdomen). No sig (significant) bleeding...In my professional medical judgment...this patient presents with an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily function, or serious dysfunction of a body organ or part...reports vaginal bleeding, vaginal discharge...Pelvic: Bimanual exam abnormal, Cervix dilated 2 cm (centimeters), fetus in breech presentation, legs at introitus on arrival..." Medical record review of a physician's progress note dated April 2, 2014, at 10:57 a.m., revealed, "Precipitous Delivery...OB notified of patients arrival to the emergency department. Infant delivered via vaginal delivery, at (9:50 a.m.)...Initial APGAR score...3 (0-10, higher score indicative of better clinical condition) Patient tolerated the procedure with difficulty..." Medical record review of a physician's progress note dated April 2, 2014, at 11:00 a.m., revealed, "...OB Called to ER for delivery of preterm with no	A2409		

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A2409	Continued From page 23 prenatal care...had presented to (facility) with abd pain and cramps...transferred to ER here where she delivered non-viable male infant...Placenta remains intact..." Medical record review of a Bereavement Loss Checklist L&D dated April 2, 2014, revealed, "...Complications this pregnancy: Preterm labor Obstetrician: (M.D. #2) Delivery Date/Time: 4-2-14 at (9:50 a.m.) Death date/Time: 4-2-14 at (9:50 a.m.)...Sex: M (male)..." Medical record review revealed, "...04/02/2014 (9:26 p.m.)...Delivery Time: Placenta - Manual." Medical record review revealed the patient was discharged on April 2, 2014. Interview with the ER Nurse Manager on May 12, 2014, at 10:20 a.m., in a conference room, revealed the facility had provided labor and delivery services since 1996, delivered infants of 35-36 weeks gestation through full term, had the capability of providing monitoring of fetal heart tones in the ED, and had OB on call. She stated, "...unless high risk, and under EMTALA we just deliver, pray for the best, and after delivery transport downtown (Hospital #2)." Interview with a Registered Pharmacist on May 12, 2014, at 11:23 a.m., in a conference room, revealed the pharmacy did not stock Indomethacin, but the medication used to delay labor could be stocked on the recommendation of physicians. Interview with the ER's Medical Director on May 12, 2014, at 11:58 a.m., in a conference room, and in the presence of the facility's Corporate	A2409		

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A2409	Continued From page 24 Preparedness/Safety Officer, revealed Patient #7 presented to Hospital #2 and he delivered Patient #7's infant. Continued interview confirmed the facility inappropriately transferred Patient #7 on April 2, 2014, and he stated, "...When patient arrived, I didn't have time to read her paperwork. The feet were already out and we had to deliver." Review of an ER Log revealed Patient #8 presented to the ER on April 18, 2014. Medical record review of an ER Record dated April 18, 2014, revealed Patient #8 presented to the ER with a complaint of abdominal pain. Medical record review of a Nursing Assessment dated April 18, 2014, at 8:58 a.m., revealed, "...pressure pain, to the right lower quadrant...on a scale 0-10 patient rates pain as 10..." Medical record review of a history and physical dated April 18, 2014, at 9:01 a.m., revealed, "...abdominal pain that started 3 days ago. Pain is sharp, constant, started in right upper but now pain to RLQ (Right Lower Quadrant) as well. No radiation to back...are constant...In my professional medical judgment....this patient presents with an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily function, or serious dysfunction of a body organ or part...(9:03 a.m.) tachycardic...tenderness to right side of abdomen...with voluntary guarding..." Medical record review of a physician's note dated	A2409	A new transfer form was developed and was approved by the Health Information Management Forms Committee on 11/24/14. It was sent to the Print Shop for print and will be ready for distribution by 12/5/2014. (See attachment #4) **Monitoring of the Corrective Action Process:** 1. Monitoring will be conducted monthly for 4 continuous months beginning January 2015- April 2015 **by the Emergency Department Nurse Manager at Erlanger East.** A review of 70 cases per month will be randomly selected to assess for compliance of appropriate completion of the new EMTALA Traisfer Form with a minimum of 90% compliance rate. If this is not met after 4 months of review, the review of records will be continued for an additional 4 months until 90% compliance is achieved, Results will be reported to the Erlanger Health System Quality Oversight Committee.	11/24/2014 12/5/2014 1/2015-4/1015

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A2409	Continued From page 25 April 18, 2014, at 9:04 a.m., revealed, "abdominal pain with signficant tenderness and guarding, will check labs, treat pain, do ultrasound." Medical record review of a Medication Administration Summary dated April 18, 2014, revealed the patient was administered pain medication at 9:18 a.m. and 10:32 a.m., and an antibiotic at 9:44 a.m, according to physician's orders. Medical record review of a Nursing Procedure: Communications dated April 18, 2014, at 9:24 a.m., revealed, "...WBC (White Blood Cell) count 32.7 (normal range 4.8-10.8), given to (MD #4)..." Medical record review of a physician's note dated April 18, 2014, at 9:47 a.m., revealed, "ultrasound positive for acute cholecystitis, will send to Main ER (Hospital #2) for surgical evaluation, will give abx (antibiotics) given patient on immunosuppressive meds with WBC 32." Medical record review of a radiology report dated April 18, 2014, at 10:08 a.m., revealed, "...large 2 cm stone in the neck of the gallbladder...gallbladder enlarged to 13 cm...in length...Impression...very suggestive of cholecystitis." Medical record review of the Emergency Department Emergency Record documentation dated April 18, 2014, at 9:50 a.m., revealed, "...Transfer to...(Hospital #2) ED..." Medical record review of a nurse's note dated April 18, 2014, at 9:58 a.m., revealed, "...Reason for transfer need for specialized care, Diagnosis: cholecystitis, Accepting Institution: (Hospital #2),	A2409	**Education:** **Education will be provided to all emergency staff on the new policy updates (EMTALA Transfer policy, EMTALA-Provision of On Call Coverage Policy , the new EMTALA Transfer Form and the education al power point presentation). This mandatory education will be distributed in notebooks to each Emergency Departments in the Erlanger Health System. All emergency department staff including physician and physician extenders will be required to read and acknowledge by signature understanding of the new policies and processes by December 31, 2014.**	12/31/2014

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A2409	Continued From page 26 Accepting physician: (MD #6)...Transported by non-urgent ambulance...consent for transfer signed..." Medical record review of the Transfer Authorization dated April 18, 2014, revealed, "Stability The patient is stablized at the time of transfer and no medical deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from this facility...OR The Patient is in a state of an emergency medical condition, and I hereby certify that based upon the information available to me at this time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility, outweigh the increased risks to the individual...OR Patient/Responsible Individual requests transfer..." Review of the Transfer Authorization revealed all three options were checked. Further review of the Transfer Authorization revealed, "...It is medically necessary to transport the patient by ambulance/air ambulance..." was not checked. Further review revealed no Confirmation Time for Hospital #2's acceptance of the patient; no time was documented when report was given to the accepting hospital staff; and no time was documented for when the patient was transferred. Medical record review of an ER Record (Hospital #2) history and physical dated April 18, 2014, at 11:45 a.m., revealed, "...Transfer from outer facility for higher level of care...Symptoms are worsening, are constant...In my professional medical judgment....this patient presents with an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate	A2409	A new transfer form was developed and was approved by the Health Information Management Forms Committee on 11/24/14. It was sent to the Print Shop for print and will be ready for distribution by 12/5/2014. (See attachment #4) **Monitoring of the Corrective Action Process:** 1. Monitoring will be conducted monthly for 4 continuous months beginning January 2015- April 2015 **by the Emergency Department Nurse Manager at Erlanger East.** A review of 70 cases per month will be randomly selected to assess for compliance of appropriate completion of the new EMTALA Transfer Form with a minimum of 90% compliance rate. If this is not met after 4 months of review, the review of records will be continued for an additional 4 months until 90% compliance is achieved. Results will be reported to the Erlanger Health System Quality Oversight Committee.	12/5/2014 1/2015-4/1015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440104	A. BUILDING _____ B. WING _____	C 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ERLANGER MEDICAL CENTER	975 E 3RD ST CHATTANOOGA, TN 37403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A2409	Continued From page 27 medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily function, or serious dysfunction of a body organ or part..." Medical record review of the Hospital #2 Emergency Department Emergency Record dated April 18, 2014, revealed the patient was transported to surgery at 1:58 p.m. Medical record review of a Discharge Summary dated April 20, 2014, revealed, "..taken to operating room for a laparoscopic cholecystectomy with intraoperative cholangiogram...on postop day 2, the day of discharge, will be discharged home..." Interview with the Corporate Preparedness/Safety Officer on May 12, 2014, at 3:35 p.m., in a conference room, confirmed Patient #8 was inappropriately transferred on April 18, 2014. Review of an ER Log revealed Patient #9 presented to the ER on April 18, 2014. Medical record review of an ER Record dated April 18, 2014, revealed, "...(3:15 p.m.) Trauma tuesday...Complaint: bilateral leg tenderness, swelling...(3:25 p.m.) Triage Information...Pain level 8 (0-10)...noticed some increased swelling...concerned about compartment syndrome...Pt has swelling and pain in left calf..." Medical record review of a history and physical dated April 18, 2014, at 4:39 p.m., revealed, "...recently admitted and released from hospital last night from traumatic injury while at work. Had skull fracture, left tibia fracture and right ankle	A2409	**Education:** **Education will be provided to all emergency staff on the new policy updates (EMTALA Transfer policy, EMTALA-Provision of On Call Coverage Policy , the new EMTALA Transfer Form and the education al power point presentation). This mandatory education will be distributed in notebooks to each Emergency Departments in the Erlanger Health System. All emergency department staff including physician and physician extenders will be required to read and acknowledge by signature understanding of the new policies and processes by December 31, 2014.**	12/31/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A2409	Continued From page 28 fracture...had PT (Physical Therapy) come out today, but was told to come directly to ER for increased swelling and pain to left calf. Worried about DVT (Deep Vein Thrombosis) poss (possible) compartment syndrome...In my professional medical judgment....this patient presents with an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily function, or serious dysfunction of a body organ or part...large amount of swelling to left calf with tenderness..." . Medical record review of a Nurse Practitioner's note dated April 18, 2014, at 4:46 p.m., revealed, "with calf swelling, with recent trauma with ankle fracture, will US (ultrasound) r/o (rule out) DVT...with US, DVT noted with fluid, concerning for compartment syndrome. (M.D. #4) spoke with (MD #11) with trauma, patient will be sent to (Hospital #2) ER downtown for further evaluation." Medical record review of a nurse's note dated April 18, 2014, at 5:09 p.m., revealed, "...Reason for transfer, pt being transferred to the ED, Diagnosis: DVT, Transported by non-urgent ambulance, Copy of patient record prepared for receiving facility, Medication reconciliation form prepared and sent to receiving facility, Patient consent for transfer signed, Family member contacted." Medical record review of the ED record revealed medications administered to the patient in the ED were Dilaudid and Phenergan for pain and	A2409		

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A2409	Continued From page 29 nausea. Medical record review revealed no transfer form, Transfer Authorization, or consent for transfer was found in the medical record. Medical record review of Hospital #2's ER Record revealed, "(5:55 p.m.)...Complaint: DVT LLE (Left Lower Extremity)...Patient transferred from another facility..." Medical record review of the ED physician history and physical dated April 18, 2014, at 7:07 p.m., revealed, "...bilateral leg and facial trauma, discharged from (Hospital #2) and then developed severe bilateral leg pain, worse on the left...There has been no change in the patient's symptoms over time, are constant...In my professional medical judgment....this patient presents with an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily function, or serious dysfunction of a body organ or part...(8:47 p.m.) Pulse, tachycardic...extremities swollen bilaterally..." Medical record review of the nursing notes revealed the patient was started on heparin (anticoagulant commonly administered for DVT) on April 18, 2014, at 7:10 p.m. Medical record review of an Admission Request dated April 18, 2014, at 8:45 p.m., revealed, "Condition: Fair...Hospital Service: Surgery - Trauma..."	A2409	**Corrective Action Plan:** Health Information Management (HIM) did not have a scanned copy of the Transfer Form for pt #9. **It is unclear why the transfer form was not in the permanent electronic medical record.** **The Erlanger East Emergency department now scans a copy of the completed/signed transfer form into the electronic emergency room record to assure the document is retained in the record.** **Monitoring of the Corrective Action Process:** Monitoring will be conducted monthly for 4 continuous months beginning January 2015- April 2015 **by the Emergency Department Nurse Manager at Erlanger East.** A review of 70 cases per month will be randomly selected to assess for compliance of appropriate completion of the new EMTALA Transfer Form and presence in the medical record with a minimum of 90% compliance rate. If this is not met after 4 months of review, the review of records will be continued for an additional 4 months until 90% compliance is achieved, Results will be reported to the Erlanger Health System Quality Oversight Committee.	June 2014 1/2015-4/1015

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A2409	Continued From page 30 Medical record review of a nurse's note dated April 18, 2014, at 10:18 p.m., revealed, "Admission: Patient admitted to telemetry unit...STAT (immediate) admission orders completed..." Medical record review of the ER Nursing Notes revealed the patient was admitted to inpatient on April 19, 2014, at 12:39 a.m. Telephone interview with the Corporate Preparedness/Safety Officer on May 13, 2014, at 1:30 p.m., revealed the facility was unable to locate a transfer form, Transfer Authorization, or consent form for transfer and confirmed Patient #9 was inappropriately transferred on April 18, 2014. Review of an ER Log revealed Patient #11 presented to the ER on March 31, 2014. Medical record review of an ER Record dated March 31, 2014, revealed, "(12:35 p.m.) Complaint: Hip Pain, right hip." Medical record review of a nurse's note dated March 31, 2014, at 12:44 p.m., revealed, "Triage Information: seen her (here) on 3/26 for rigt (right) hip and leg pain. pt continues to have this pain and is not able to sleep well. Pt has been taking tylenol and motrin that is not helping pain." Medical record review of a history and physical dated March 31, 2014, at 12:44 p.m., revealed, "...Cerebral Palsy, seizure disorder, cerebral atonia, severe thoracolumbar scoliosis, osteoporosis...(12:58 p.m.) patient was seen last Wednesday for bruising to right leg. Unsure of	A2409	The HIM department uses the scanning process for all records scanned and verification that all documents received are scanned. In addition HIM retains the hard copy of the record for 60 days before they are destroyed - ongoing process.	Ongoing

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A2409	Continued From page 31 any injury or trauma. Patient is non weight bearing. wheel chair bound only. Uses assistance when transferring from wheelchair to recliner...patient has CP (Cerebral Palsy), is non-verbal...Gradual onset of symptoms, 7, days prior to arrival. There has been no change in the patient's symptoms over time, are constant...In my professional medical judgment....this patient presents with an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily function, or serious dysfunction of a body organ or part...(1:01 p.m.) Patient appears, in mild pain distress, Patient appears to be uncomfortable...Lower extremity exam included finidngs of inspection abnormal no abrasions, contusions present, no deformity...right medial upper thigh, Range of motion, limited to the right hip..." Medical record review of a Family Nurse Practitioner's note dated March 31, 2014, at 1:02 p.m., revealed, "...brought back in for persistent pain. X-ray over-read shows femoral neck fracture. Will CT and call ortho (orthopedics). Caretaker is unsure of any injury or trauma patient has had in the past week...Spoke with (M.D. #6), will look at CT and speak with ortho attending. Patient will need to be sent to ER to be evaluated by ortho." Medical record review of a radiology report (CT) dated March 31, 2014, at 1:13 p.m., revealed, "Comparison: Right femur fracture, 3/26/2014...Impression: An acute, comminuted fracture of right femoral neck with markedly	A2409		

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A2409	Continued From page 32 displaced fracture fragments as discussed..." Medical record review of a nurse's note dated March 31, 2014, at 3:30 p.m., revealed, "...Reason for transfer need for specialized care, Diagnosis: Femur Fracture, accepting institution (Hospital #2), Accepting physician (M.D. #7), Referring physician: (M.D. #1/FNP), Transported by non-urgent ambulance..." Medical record review of a Transfer Authorization dated March 31, 2014, revealed, "Stability The patient is stablized at the time of transfer and no medical deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from this facility...OR The Patient is in a state of an emergency medical condition, and I hereby certify that based upon the information available to me at this time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility, outweigh the increased risks to the individual...OR Patient/Responsible Individual requests transfer..." Review of the Transfer Authorization revealed all three options were checked. Further review of the Transfer Authorization revealed it was not documented who the aceepting physician was or who the transferring facility was. Medical record review of the ER record dated March 31, 2014, at 3:37 p.m., revealed, "...Disposition Transport: Ambulance, Patient left the department..." Medical record review of a Orthopedic Consultation Report (Hospital #2) dated March 31, 2014, revealed, "...signs of painful hip since	A2409	A new transfer form was developed and was approved by the Health Information Management Forms Committee on 11/24/14. It was sent to the Print Shop for print and will be ready for distribution by 12/5/2014. (See attachment #4) **Monitoring of the Corrective Action Process:** 1. Monitoring will be conducted monthly for 4 continuous months beginning January 2015- April 2015 **by the Emergency Department Nurse Manager at Erlanger East**. A review of 70 cases per month will be randomly selected to assess for compliance of appropriate completion of the new EMTALA Transfer Form and presence in the medical record with a minimum of 90% compliance rate. If this is not met after 4 months of review, the review of records will be continued for an additional 4 months until 90% compliance is achieved, Results will be reported to the Erlanger Health System Quality Oversight Committee.	12/5/2014 1/2015-4/1015

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A2409	Continued From page 33 last Wednesday (March 26, 2014)...At that time, x-rays were taken, which in retrospect showed a femoral neck fracture that was missed, and the patient was sent (home)...would then show signs of significant pain any time his leg was moved or anytime he was transferred from bed to chair...x-ray of the right hip shows a displaced, shortened and varus femoral neck fracture. CT confirms this fracture and also shows comminution, as well as what appears to be a Pauwels III orientation of the femoral neck fracture...Patient will likely go to the operating room tomorrow..." Interview with the Corporate Preparedness/Safety Officer on May 12, 2014, at 3:00 p.m., in a conference room, confirmed Patient #11 was inappropriately transferred. Interview with the Corporate Preparedness/Safety Officer on May 9, 2014, at 2:40 p.m., in a conference room, revealed the facility did not have current approved EMTALA policies for Hospital #1 (facility or the East Campus) except for a transfer policy. Further interview confirmed the unapproved policy with an origination date of March 2014 was under review. Interview with the ED Medical Director on May 12, 2014, at 11:58 a.m., in a conference room and the presence of the Corporate Preparedness/Safety Officer, revealed EMTALA policy "verbage is in our bylaws."	A2409	**Education:** **Education will be provided to all emergency staff on the new policy updates (EMTALA Transfer policy, EMTALA-Provision of On Call Coverage Policy , the new EMTALA Transfer Form and the education al power point presentation). This mandatory education will be distributed in notebooks to each Emergency Departments in the Erlanger Health System. All emergency department staff including physician and physician extenders will be required to read and acknowledge by signature understanding of the new policies and processes by December 31, 2014.**	12/31/2014

Proof Of Publication

HSDA - Letter Of Intent
HSDA - Publication Of Intent
Affidavit Of Publication

LETTER OF INTENT
TENNESSEE HEALTH SERVICES & DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Chattanooga Times Free Press, which is a newspaper of general circulation in Hamilton County, Tennessee, on or before January 8, 2016, for one day.

This is to provide official notice to the Health Services & Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et. seq.*, and the Rules of the Health Services & Development Agency, that Children's Hospital @ Erlanger and Erlanger East Hospital, owned by the Chattanooga-Hamilton County Hospital Authority D/B/A Erlanger Health System, with an ownership type of governmental, and to be managed by itself, intends to file an application for a Certificate of Need ("CON") to modernize the CON originally issued in 2004 (no. CN0405-047AE) by requesting approval for the initiation of a ten (10) bed Level 3 Neonatal Intensive Care service, and transfer of ten (10) medical/surgical beds from Erlanger Medical Center to Erlanger East Hospital and reclassify them to Neonatal Intensive Care beds. If approved, the number of hospital beds at Erlanger East Hospital will total 123. The expansion of Erlanger East Hospital (CON No. CN0405-047AE) is in process. No other health care services will be initiated or discontinued.

The facility and equipment will be located at Erlanger East Hospital, 1755 Gunbarrel Road, Chattanooga, Hamilton County, Tennessee, 37421. The total project cost is estimated to be $ 7,021,555.00.

The anticipated date of filing the application is January 13, 2015.

The contact person for this project is Joseph M. Winick, Sr. Vice President, Erlanger Health System, 975 East 3rd Street, Chattanooga, Tennessee, 37403, and by phone at (423) 778-7274.

Joseph M. Winick	January 5, 2015	Joseph.Winick@erlanger.org
	Date:	E-Mail:

The Letter Of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services & Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter Of Intent must contain the following statement pursuant to T.C.A. §68-11-1607(c)(1): (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

PUBLICATION OF INTENT

TENNESSEE HEALTH SERVICES & DEVELOPMENT AGENCY

Instructions To Newspaper

The following shall be published in the "Legal Notices" section of the newspaper in a space no smaller than four (4) inches.

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services & Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et. seq.*, and the Rules of the Health Services & Development Agency, that Children's Hospital @ Erlanger and Erlanger East Hospital, owned by the Chattanooga-Hamilton County Hospital Authority D/B/A Erlanger Health System, with an ownership type of governmental, and to be managed by itself, intends to file an application for a Certificate of Need ("CON") to modernize the CON originally issued in 2004 (no. CN0405-047AE) by requesting approval for the initiation of a ten (10) bed Level 3 Neonatal Intensive Care service, and transfer of ten (10) medical/surgical beds from Erlanger Medical Center to Erlanger East Hospital and reclassify them to Neonatal Intensive Care beds. If approved, the number of hospital beds at Erlanger East Hospital will total 123. The expansion of Erlanger East Hospital (CON No. CN0405-047AE) is in process. No other health care services will be initiated or discontinued.

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Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services & Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

Pursuant to T.C.A. § 68-11-1607(c)(1): (A) Any health care institution wishing to oppose a Certificate Of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

2788719
ERLANGER STRATEGIC

STATE OF TENNESSEE
HAMILTON COUNTY

Before me personally appeared Jim Stevens who being duly sworn, that he is the Legal Sales Representative of the "CHATTANOOGA TIMES FREE PRESS" and that the Legal Ad of which the attached is a true copy, has been published in the above said Newspaper and on the website on the following dates, to-wit:

January 8, 2016

And that there is due or has been paid the "CHATTANOOGA TIMES FREE PRESS" for publication of such notice the sum of $583.30 Dollars. (Includes $10.00 Affidavit Charge)

Jim Stevens

Sworn to and subscribed before me, this 8th day of January, 2016.

Amanda Crawford

My Commission Expires 10/17/2018

AMANDA CRAWFORD
STATE OF TENNESSEE
NOTARY PUBLIC
HAMILTON COUNTY
MY COMMISSION EXPIRES OCTOBER 17, 2018

Chattanooga Times Free Press

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

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39566653

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

February 3, 2016

Joseph Winick
Erlanger Health Systems
975 East 3rd Street
Chattanooga, TN 37403

RE: Certificate of Need Application – Children's Hospital at Erlanger and Erlanger East Hospital- CN1601-002
The initiation of a 10 bed Level 3 Neonatal Intensive Care service, through the transfer of 10 medical/surgical beds from Erlanger Medical Center to Erlanger East Hospital located at 1755 Gunbarrel Road in Chattanooga (Hamilton County), TN, 37416 and reclassification of the 10 beds as Level III Neonatal Intensive Care bed. These beds will be built in 8,805 sf of new construction resulting in a project cost in excess of $5M. If approved, the licensed bed complement of Erlanger East Hospital will increase from 113 to 123 total beds. The project does not contain the acquisition of major medical equipment or the initiation or discontinuance of any other health service. The estimated project cost is $7,021,555

Dear Mr. Winick:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need. Please be advised that your application is now considered to be complete by this office.

Your application is being forwarded to Trent Sansing at the Tennessee Department of Health for Certificate of Need review by the Division of Policy, Planning and Assessment. You may be contacted by Mr. Sansing or someone from his office for additional clarification while the application is under review by the Department. Mr. Sansing's contact information is Trent.Sansing@tn.gov or 615-253-4702.

In accordance with Tennessee Code Annotated, §68-11-1601, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on February 1, 2016.. The first sixty (60) days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the sixty (60) day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review within the thirty (30)-day period immediately following. You will receive a copy of their findings. The Health Services and Development Agency will review your application on April 27, 2016.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Melanie M. Hill
Executive Director

cc: Trent Sansing, TDH/Health Statistics, PPA

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

MEMORANDUM

TO: Trent Sansing, CON Director
Office of Policy, Planning and Assessment
Division of Health Statistics
Andrew Johnson Tower, 2nd Floor
710 James Robertson Parkway
Nashville, Tennessee 37243

FROM: Melanie M. Hill
Executive Director

DATE: February 3, 2016

RE: Certificate of Need Application
Children's Hospital at Erlanger and Erlanger East Hospital
CN1601-002

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on February 1, 2016 and end on April 1, 2016.

Should there be any questions regarding this application or the review cycle, please contact this office.

Enclosure

cc: Joseph Winick

LETTER OF INTENT
TENNESSEE HEALTH SERVICES & DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Chattanooga Times Free Press, which is a newspaper of general circulation in Hamilton County, Tennessee, on or before January 8, 2016, for one day.

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This is to provide official notice to the Health Services & Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et. seq.*, and the Rules of the Health Services & Development Agency, that Children's Hospital @ Erlanger and Erlanger East Hospital, owned by the Chattanooga-Hamilton County Hospital Authority D/B/A Erlanger Health System, with an ownership type of governmental, and to be managed by itself, intends to file an application for a Certificate of Need ("CON") to modernize the CON originally issued in 2004 (no. CN0405-047AE) by requesting approval for the initiation of a ten (10) bed Level 3 Neonatal Intensive Care service, and transfer of ten (10) medical/surgical beds from Erlanger Medical Center to Erlanger East Hospital and reclassify them to Neonatal Intensive Care beds. If approved, the number of hospital beds at Erlanger East Hospital will total 123. The expansion of Erlanger East Hospital (CON No. CN0405-047AE) is in process. No other health care services will be initiated or discontinued.

The facility and equipment will be located at Erlanger East Hospital, 1755 Gunbarrel Road, Chattanooga, Hamilton County, Tennessee, 37421. The total project cost is estimated to be $ 7,021,555.00.

The anticipated date of filing the application is January 13, 2015.

The contact person for this project is Joseph M. Winick, Sr. Vice President, Erlanger Health System, 975 East 3rd Street, Chattanooga, Tennessee, 37403, and by phone at (423) 778-7274.

Joseph M. Winick	January 5, 2015	Joseph.Winick@erlanger.org
	Date:	E-Mail:

==========

The Letter Of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services & Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

==========

The published Letter Of Intent must contain the following statement pursuant to T.C.A. §68-11-1607(c)(1): (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

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Supplemental #1
-ORIGINAL-

Erlanger East Hospital

CN1601-002

SUPPLEMENTAL #1
January 26, 2016
9:00 am

SUPPLEMENTAL INFORMATION

Chattanooga-Hamilton County Hospital Authority

D / B / A

Erlanger East Hospital

Application To Modernize The Certificate Of Need
Originally Issued In 2004 (No. CN0405-047AE)
By Initiating A Level III Neonatal Intensive Care Unit,
Reclassifying Medical / Surgical Beds To Neonatal,
And Transferring Medical / Surgical Beds

Application Number CN1601-002

January 26, 2016

ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

SUPPLEMENTAL #1

January 26, 2016
9:00 am

Supplemental Responses To Questions Of The Tennessee Health Services & Development Agency

1.) Section A, Applicant Profile, Item 9 (Bed Complement Table) and Section B, Project Description, Item II.B (Changes In Bed Complement).

The table in Section A for Erlanger East Hospital and the discussion in Section B of related bed changes is noted. The 6 NICU Level II beds approved in CN0407-067A that were placed into service in 2004 are not shown in Line F of the table. Please clarify.

Review of the Licensed Health Facilities Report on the Tennessee Department of Health website last updated on 01/15/2016 revealed that Erlanger East Hospital and Erlanger North Hospital operate under the 788-bed combined license of Erlanger Medical Center (license # 00000140). Using the template on page 6 of the application, please provide a combined bed complement table with breakout by classification of the 788 total beds of Erlanger Medical Center, inclusive of any bed changes as a result of the proposed project and any outstanding CON projects that are in process of being completed.

In your response, please complete the table below showing the current licensed bed complement by campus, including the number of CON beds that remain in progress and the combined bed complement status in Year 1 of the project. In the space below the table, please identify the approved CON project #s that apply.

EMC Licensed Hospital Beds in Hamilton County as of 01/2016

Bed Type	Erlanger Main Campus 1/2016	Erlanger North Satellite Campus 1/2016	Erlanger East Satellite Campus 1/2016	EMC Total Combined Beds 1/2016	EMC Total Combined Beds Year 1
Medical					
Surgical					
Obstetrical					
ICU/CCU					

Neonatal ICU					
Pediatric					
Adult Psychiatric					
Geriatric Psychiatric					
Subtotal-Existing Beds				788	

Response

Prior to the adoption of the *Tennessee Perinatal Guidelines* (v. 7, adopted April 24, 2014) which now specify neonatal levels of care as I, II, III and IV, the *Guidelines* (v. 6 and prior) delineated neonatal levels of care as being I, II-A, II-B, and III. With the CON (no. CN0407-067A) which *Erlanger East Hospital* obtained in 2004 pertaining to the Level II *Special Care Nursery*, this has been identified as a Level II-A unit. The Level II beds at Erlanger East Hospital were grouped in the medical/surgical bed category.

The tables requested for clarification of the licensed bed complement follow.

SUPPLEMENTAL #1

January 26, 2016
9:00 am

		Erlanger East Licensed Beds July, 2004	*(*) CON Beds Implemented*	*(*) CON Beds Remaining*	*Current Staffed Beds*	*Beds Proposed*	*TOTAL Beds at Completion*
A.	Medical	4		+ 42	8	50	50
B.	Surgical	8		+ 22	4	26	26
C.	Long-Term Care Hospital						
D.	Obstetrical	16	+ 9		25	25	25
E.	ICU / CCU						
F.	Neonatal		+ 6	+ 16	6	22	22
G.	Pediatric						
H.	Adult Psychiatric						
I.	Geriatric Psychiatric						
J.	Child / Adolescent Psychiatric						
K.	Rehabilitation						
L.	Nursing Facility (Non – Medicaid Certified)						
M.	Nursing Facility Level 1 (Medicaid only)						
N.	Nursing Facility Level 2 (Medicare only)						
O.	Nursing Facility Level 2 (dually certified Medicaid / Medicare)						
P.	ICF / MR						
Q.	Adult Chemical Dependency						
R.	Child and Adolescent Chemical Dependency						
S.	Swing Beds						
T.	Mental Health Residential Treatment						
U.	Residential Hospice						
	TOTAL	28	+ 15	+ 80	43	123	123

(*) CON Beds approved but not yet in service.

Notes

(1) *Erlanger East Hospital* received a CON to transfer six (6) beds from *Erlanger Medical Center* (no. CN0407-067A) for it's Level II *Special Care Nursery* and this has been implemented.

(2) *Erlanger East Hospital* holds a CON for the transfer of up to 79 beds from *Erlanger Medical Center* (no. CN0405-047AE). Nine (9) beds have already been implemented in this process.

(3) *Erlanger East Hospital* has 70 beds remaining (46 medical & 24 surgical) to implement under CON No. CN0407-047AE. Together with the current CON application (no. CN1601-002) for ten (10) Level III NICU beds, there are a total of 80 beds which remain to be implemented.

(4) The total of neonatal beds at Erlanger East Hospital upon completion of all projects will twenty-two (22), twelve (12) Level II beds and ten (10) Level III beds.

EMC Licensed Hospital Beds in Hamilton County as of Jan - 2016

Bed Type	Erlanger Main Campus 1/2016	Erlanger North Satellite Campus 1/2016	Erlanger East Satellite Campus 1/2016	EMC Total Combined Beds 1/2016	EMC Total Combined Beds Year 1

Medical	293	27	12	332	319
Surgical	151	14	6	171	165
Obstetrical	40	-	25	65	65
ICU/CCU	91	4	-	95	95
Neonatal ICU	64	-	-	64	83
Pediatric	49	-	-	49	49
Adult Psychiatric	-	-	-	-	
Geriatric Psychiatric	-	12	-	12	12
Total-Existing Beds	688	57	43	788	788

2.) Section B, Project Description, Item I.9 (Executive Summary Description).

The detailed summary is noted. Please add a section that provides an overview of the clinical scope of services that apply to the proposed 10 bed Level III NICU unit. In your response, please identify the key differences from the services provided by the hospital's existing 6 bed Level II NICU approved in CN0407-067A. Please also include a brief description of the clinical leadership of the service under management arrangement with the Children's Hospital @ Erlanger.

Service Area - The description with related attachment identifying the counties included in the 4 state geographical service area and their designation as a PSA, SSA or TSA county is noted. For Tennessee only, Hamilton County is the applicant's PSA, 9 counties are in the SSA and 8 counties are included in the TSA. Please provide a brief overview that addresses the relationship of the applicant's service area to the Southeast Tennessee Regional Perinatal service area. In your response, please revise the list of service area counties by adding a column that identifies the perinatal region for each TN county included in the list.

Need - The overview related to the need for the project is noted. In addition to need arising from the factors identified by the applicant, including

increased NICU utilization at Erlanger Children's Hospital's existing 64-bed Level III NICU, are patient transfers from Erlanger East Hospital's existing Level II unit also contributing to the need for this project? If so, please identify the number of transfers over the most recent 12-month period for which information is available.

Existing Resources- in addition to the existing hospital NICU units in the applicant's primary service area (Hamilton County), secondary service area and tertiary service area counties, please also include a brief overview of resources available through the Tennessee Department of Health's designated Southeast Tennessee Perinatal Region.

Staffing- Please provide an overview of the hospital's arrangements planned for coverage of the proposed Level III unit by neonatologists and neonatal nurse practitioners. In your response, please identify any key changes from coverage currently provided for the existing 6-bed Level II NICU approved in CN0407-067A. If coverage is or will be provided through a contractual arrangement (e.g. Professional Services Agreement), please provide a copy of the existing or draft document that identifies the key responsibilities of the parties.

Response

The nurse managers for the neonatal units at *Erlanger East Hospital* … Level II *Special Care Nursery* and Level III NICU … will both report to the Director of the NICU service at Children's Hospital @ Erlanger. This management structure will ensure that nursing policies and education are followed uniformly by all neonatal units. The NICU management group will work together in a collaborative manner to transfer infants needing higher levels of care to the Level IV NICU at *Children's Hospital @ Erlanger* when necessary.

Pertaining to the differences between the Level II unit currently at Erlanger East Hospital and the level III NICU which is the subject of this CON application, infants in the Level III NICU will include non-surgical complications of infants will include conditions such as low birth weight, sepsis, respiratory distress and

hyperbilirubinemia. The Level II unit will not treat infants with these type of conditions.

The sections identified in which additional information has been requested, have been addressed.

Service Area

The NICU for *Children's Hospital @ Erlanger* is well situated for the *Southeast Tennessee Perinatal Regional* service area as evidenced by the patient origin. In CY 2015, 67% of NICU patients were from the ten (10) county service area which comprises the *Southeast Tennessee Perinatal Regional* service area. In CY 2014 64% of NICU patients came from this geography.

Need

Transfers from the Level II unit at *Erlanger East Hospital* contributing to the need for this project is minimal. As evidence of this, the number of transfers to the NICU at *Children's Hospital @ Erlanger* in CY 2015 was 26.

As demonstrated by the payor mix data in this supplemental information, 67% of our NICU utilization is *TennCare* and Medicaid, evidencing the need for a "system of care" among those which are most vulnerable, the neonatal patients of low income families. Thus, it is apparent to *Erlanger* management that we need to provide such a "system of care" within the neonatal healthcare system in southeast Tennessee.

Need is also a function of enabling access for less high risk mothers and infants and providing an opportunity to deliver at *Erlanger East Hospital*. This will decrease the utilization of the NICU for *Children's Hospital @ Erlanger*, and provide the same high level of care with the same neonatologist and Neonatal Nurse Practitioner's at both NICU's.

Existing Resources

In addition to the NICU and neonatal services that are offered by *Children's Hospital @ Erlanger*, as a *Tennessee Regional Perinatal Center* the program provides direct medical care and consultation services to women with

complex medical conditions or with high risk pregnancy. We also provide ongoing education to other community hospitals and providers in the *Tennessee Southeast Perinatal Region*.

Staffing

The current professional staffing of the Level II unit at *Erlanger East Hospital* is one (1) Neonatologist and 24 hour coverage of a Neonatal Nurse Practitioner. Per the Medical Director, Dr. Lisa Lowery-Smith, it is not anticipated that there will be any changes with the addition of the Level III NICU. Professional service coverage is provided through a contractual arrangement with *Pediatrix Medical Group of Tennessee, P.C.* As requested, a copy of the contract is attached to this supplemental information.

Clinical Scope Of Services

The neonatal healthcare team at *Erlanger East Hospital* is committed to the care of non-surgical complications of infants after birth which may include prematurity, low birth weight, sepsis, respiratory distress, hyperbilirubinemia and other conditions.

3.) Section B, Project Description, Item II.A.

The Square Footage and Cost per Square Foot Chart is noted.

Is the proposed 8,805 square foot unit on the 2nd floor of the hospital currently in use by another hospital service or will it require build-out of existing shell space? Please clarify why the project involves new construction.

There appears to be an error in the Square Footage Chart with the $7,005,221 total construction cost in lieu of the $3,551,753 cost identified in Line A.5 of the Project Cost Chart, the 01/06/2016 architect letter, and the applicant's comments on page 56. Please provide a revised Square Footage Chart for the application.

Response

The proposed Level III NICU at *Erlanger East Hospital* will not be in space currently occupied by another hospital department, it will require build out of space provided by new construction.

A revised *Square Footage Chart* is attached to this supplemental information.

4.) Section B, Project Description, Item II.B (Bed Changes) and Section C, Need, Item 2 (Development Plans)

The detailed discussion of beds changes in this project, other outstanding CON approved projects, and projects the applicant identifies on pages 13, 16 and elsewhere in the application not requiring CON approval (e.g. increase from 64 to 73 NICU beds at Erlanger Children's Hospital) are noted. Please complete the table or a similar version of the applicant's choosing to help facilitate an understanding of the changes planned or underway for Erlanger Medical Center's NICU bed service across multiple campuses within the next 5 years.

Erlanger Medical Center NICU Current and Projected Bed Changes

Campus	NICU beds as of 1/2016	Proposed NICU Bed Changes CN1601-002	Other CON Projects with NICU Bed Changes	Other Projects with NICU Bed Changes not Requiring CON Approval	Total Projected NICU Beds by 1/2018	Total Projected NICU Beds by 1/2020
EMC Main Campus						
Children's Hospital @Erlanger	64 Level III					
Erlanger East Satellite	6 Level II					
Erlanger North Satellite						
Total EMC						

Note: For NICU bed counts, please include bed level designation in accordance with current state perinatal guidelines. For Other approved CON projects in progress, please identify the CON project number and expiration date.

Response

A chart which details the proposed bed changes has been completed, as requested.

Erlanger Health System NICU -- Current & Projected Bed Changes

Campus	Neonatal Beds As Of January, 2016	Proposed Bed Changes Per CON	Proposed Bed Changes w/o CON	Projected Neonatal Beds As Of January, 2018	Projected Neonatal Beds As Of January, 2020
Children's Hospital @ Erlanger (Main Campus)	64 Level IV		+ 9 Level IV	73	90
Erlanger East	6 Level II	+ 10 Level III	+ 6 Level II	22	22
Erlanger North	0	0	0	0	0
Total- Existing Beds	70	+ 10	+ 15	95	112

Notes

(1) *Erlanger East Hospital* has submitted the current CON application (no. CN1601-002) for ten (10) Level III NICU beds.

(2) *Children's Hospital @ Erlanger* will reclassify nine (9) adult "medical/surgical" beds to neonatal Level IV beds.

(3) *Erlanger East Hospital* holds a CON for the transfer of up to 79 beds from *Erlanger Medical Center* (no. CN0405-047AE). Nine (9) beds have already been implemented in this process. As part of this expansion of *Erlanger East Hospital*, we will re-classify six (6) adult "medical/surgical beds" to neonatal Level II beds.

(4) *Erlanger Health System* has developed long term plans to build a new *Children's Hospital*. This project includes a Level IV NICU of 90 beds, so it has been included in the column for January, 2020. However, the precise timeline is not fully known.

5.) Section C, Need (Project Specific Criteria: NICU Items 1 and 2).

The responses are noted. Using 2020 population estimates and live births data for the most recent calendar year period available from the Tennessee

SUPPLEMENTAL #1

January 26, 2016
9:00 am

Department of Health, please complete the table below showing the calculation used to project NICU bed need in 2020 for the Applicant's 18 county service area (PSA, SSA, TSA), including the 10 counties in the Southeast Tennessee Perinatal Region (*identified in table by asterisk).**

Projected Births with Fertility Rates and NICU Bed Need in Applicant's TN Service Area (*total births-all ages per 1,000 females aged 15-44 using 2014 TN resident data*)

COUNTY	EMC Service Area Type	Births	Fertility Rate	Age 15-44 Pop. 2020	Births 2020	Bed Need 2020
Bledsoe*	SSA					
Bradley*	SSA					
Grundy*	SSA					
Hamilton*	PSA					
McMinn*	SSA					
Marion*	SSA					
Meigs*	SSA					
Polk*	SSA					
Rhea*	SSA					
Sequatchie*	SSA					
Coffee	TSA					
Subtotal-Southeast Perinatal Region	**10 Counties**					
Cumberland	TSA					
Franklin	TSA					
Loudon	TSA					
Monroe	TSA					
Roane	TSA					
Van Buren	TSA					
Warren	TSA					
Total-EMC Service Area	**18 Counties**					

Response

As requested, the table has been completed.

Projected Births With Fertility Rates & NICU Bed Need In Applicant's Tennessee Service Area
(Total Births - All Ages Per 1,000 Females Aged 15-44 Using Tennessee Resident Data)

County	EMC Service Area	Females Age 15-44 CY 2014	Births CY 2014	Fertility Rate	Females Age 15-44 CY 2020	Projected Births CY 2020	Bed Need CY 2020
Bledsoe (*)	SSA	1,941	119	61.3	1,940	119	1.0
Bradley (*)	SSA	20,475	1,206	58.9	21,288	1,254	10.0
Grundy (*)	SSA	2,316	151	65.2	2,051	134	1.1
Hamilton (*)	PSA	69,764	4,144	59.4	70,095	4,164	33.3
Marion (*)	SSA	5,000	324	64.8	4,543	294	2.4
McMinn (*)	SSA	9,437	553	58.6	9,313	546	4.4
Meigs (*)	SSA	1,925	102	53.0	6,307	334	2.7
Polk (*)	SSA	2,850	177	62.1	2,881	179	1.4
Rhea (*)	SSA	5,944	384	64.6	6,192	400	3.2
Sequatchie (*)	SSA	2,508	152	60.6	2,701	164	1.3
Subtotal - Southeast Perinatal Region	10 Counties	122,160	7,312	61.3	127,311	7,588	60.8
Coffee	TSA	9,816	693	70.6	10,180	719	5.8
Cumberland	TSA	8,405	548	65.2	8,661	565	4.5
Franklin	TSA	7,600	399	52.5	7,609	399	3.2
Loudon	TSA	7,932	510	64.3	8,121	522	4.2
Monroe	TSA	7,627	527	69.1	7,815	540	4.3
Roane	TSA	8,457	433	51.2	8,383	429	3.4
Van Buren	TSA	893	61	68.3	818	56	0.4
Warren	TSA	1,160	77	66.4	7,226	480	3.8
Total - EMC Service Area - In Tennessee	18 Counties	174,050	10,560	62.2	186,124	11,298	90.4
					Occupancy Adjustment		80%
			CY 2020 Bed Need With Occupancy Adjustment				113.0

Notes

(1) The formula for estimated births in CY 2020 is … Females-2020 x Fertility Rate = Projected Births-2020.

(2) The formula for estimated bed need in CY 2020 is … (Projected Births-2020 / 1000) x 8 beds per thousand = Bed Need-2020.

(3) The bed need calculated by the table provided by the *Tennessee Health Services Agency* is unadjusted. Including an occupancy adjustment of 80%, the bed need of 116.4 is reflective of the proposed neonatal CON standards currently being developed.

6.) Section C, Need (Project Specific Criteria: NICU Items 5 and 7).

Item 5 - The response indicating compliance with existing Perinatal Care System Guidelines is noted. In terms of physician direction and staffing in conjunction with Children's Hospital @ Erlanger, is

there an existing contract, letter of intent or draft operating agreement that documents the responsibilities of the parties for the management of Erlanger East Hospital's existing 6-bed Level II NICU and the 10 bed Level III NICU proposed in this project? Please clarify. In your response, please provide a resume for the medical director of the NICU. If possible, please include a letter from the medical director expressing his/her support for the project.

How will NICU coverage by neonatologists and neonatal nurse practitioners be split between Children's Hospital @ Erlanger and Erlanger East?

Is there a pool of other board certified neonatologists that will be available to care for Level III infants? If possible, please provide a copy of their Tennessee license and licensure profile.

Who provides the actual neonatal transport service for Erlanger East Hospital? Please briefly describe any changes related to the proposed addition of 10 Level III NICU beds. In your response, please also address the availability of air transport.

Please provide the types of pediatric sub-specialties that will be available to support the proposed Level III NICU.

Please clarify if radiology services will be available 24 hours a day including the capability to perform portable radiological studies in the nursery.

Item 7 - The response is noted. To help facilitate review of compliance with the Perinatal Standards (7th Edition) by the perinatal committee members, please complete the table below.

Standard	Status of Compliance (*met, in progress*)	Documentation of compliance (*page #*)	Documentation of Plan to Comply (*page #*)	Comments
A. Educational Services				
1. Parent				
2. Nurses				
3. Physicians				
4. NRP & STABLE Provider Status				
B. Neonatal care (Standards 1-8)				

C. Consultation/Transfer – Neonatal Transport (Standards 1a-1c)				
D. Maintenance of Data & Assessment of Quality Measures				

Response

Item 5

The current professional staffing of the Level II *Special Care Nursery* at *Erlanger East Hospital* is one (1) Neonatologist and 24 hour coverage of a Neonatal Nurse Practitioner. Per the Medical Director of the Level II unit at *Erlanger East Hospital*, Dr. Lisa Lowery-Smith, it is not anticipated that there will be any changes with the addition of the Level III NICU. Dr. Smith will also serve as the Medical Director of the Level III NICU and also serves concurrently as the Medical Director for the level IV NICU at *Children's Hospital @ Erlanger*. Professional service coverage is provided through a contractual arrangement with *Pediatrix Medical Group of Tennessee, P.C.* As requested, a copy of the *Pediatrix* contract, a letter from Dr. Smith expressing support for this project, and a copy of Dr. Smith's *Curriculum Vitae* are attached to this supplemental information.

Currently neonatologists rotate between *Children's Hospital @ Erlanger* and *Erlanger East Hospital*. This same practice will continue with the addition of the Level III NICU. Currently a pool of six (6) full-time and four (4) PRN board certified neonatologists rotate between Erlanger's main campus and East campus. As requested, copies of the physician licenses are attached to this supplemental information.

The neonatal ambulance is based at *Children's Hospital @ Erlanger* and currently transports infants from *Erlanger East Hospital* to *Children's Hospital @ Erlanger*, and vice versa. The same process will continue with the addition of the Level III NICU at *Erlanger East Hospital*.

Pediatric sub-specialties will be located at *Children's Hospital @ Erlanger* and are available immediately, when needed. This is in compliance with the *Tennessee Perinatal Guidelines* which stipulate that sub-specialists need to be at the site, or closely related institution by prearranged consultative arrangement.

The Pediatric sub-specialty's which are available are Neurology, Hematology, Gastroenterology, Endocrinology, Nephrology, Cardiology, Dermatology, Genetics, Infection Control, Neurological Surgery, Pediatric Surgery, Anesthesiology, Craniofacial Surgery, Orthopedics, Pulmonology, Urology, Pediatric Sleep Studies and Radiology.

Radiology services will be available 24 hours a day for the Level III NICU at *Erlanger East Hospital*, including the capability to perform portable radiological studies in the nursery.

Item 7

The table requested has been completed.

Standard	Status of Compliance *(met, in progress)*	Documentation of compliance *(page #)*	Documentation of Plan to Comply *(page #)*	Comments
A. Educational Services				
1. Parent	Met	Documentation of Compliance regarding different classes is kept with educators. On-going education by parents happens throughout the stay of their infant.		Several education classes are offered regarding perinatal education.
2. Nurses	Met	Currently have documentation in each nurse's file for yearly education provided by educator.		
3. Physicians	Met	40 hours of CME education is needed for physicians. The documentation of compliance is through Pediatrix		
4. NRP & STABLE Provider Status	Met	All NICU nurses are required to have NRP and Stable. The documentation is located in each of their personnel files.		
B. Neonatal care (Standards 1-8)	Met/in progress	*** See below.		
C. Consultation/Transfer – Neonatal Transport (Standards 1a-1c)	Met/Children's transport team	Neonatal transport team keeps records in each of their files regarding compliance.		
D. Maintenance of Data & Assessment of Quality Measures	In progress		Upon Approval-will participate	

			with Children's NICU in Vermont Oxford quality measures.	

Response To Educational Services

1. Resuscitation: The Level III NICU currently meets compliance. Every nurse is NRP/Stable certified. All equipment is currently in place within labor and delivery rooms including blended 02, bag mask, infant warmers, neonatal crash carts etc. Per the most recent edition of the *American Heart Association* and *American Academy of Pediatrics, Neonatal Resuscitation Guidelines.*
2. Transport from Delivery Room to the Special Care Nursery: The Level III NICU currently meets compliance. Currently have 2 covered appropriately equipped pre-warmed transport incubators with blended oxygen to support infants to the NICU.
3. Transitional Care: The Level III NICU currently meets compliance. NRP/ Stable certification which prepares nurses to identify and response to early manifestations of neonatal disorders. This responsibility is already part of the training for all NICU healthcare personal currently working in current level II NICU.
4. Care of Sick Neonates:
    a. Met
    b. Met
    c. Met
    d. Met
    e. Met
    f. Met
    g. Met
    h. Met
    i. Met
    j. Met
5. Mechanical Ventilator Support:
    a. Met – 24 hours coverage of neonatal nurse practitioner
    b. In Progress – RT has some specific education regarding neonatal disorders more education will take place in collaboration with RT and Children's hospital to insure higher level of infants is covered.
    c. Met
    d. Met. *Erlanger East Hospital* NICU infants will be transported to *Children's Hospital @ Erlanger* NICU as needed. The Children's transport team has inhaled nitric oxide available during transport.
6. Diagnostic Imaging
    a. In progress – advanced imaging, with interpretation on an urgent basis including CT, MRI are available. Echocardiography will be available when the Level III NICU begins operation.
7. Laboratory Services: Met
8. Blood Bank Services Met

7.) Section C, Need, Items 3 and 4.a (Service Area).

Item 3 - The response is noted. It appears Cumberland County was omitted from the TN Service Area map showing the 18 counties included in the applicant's service area for the project. Please revise the map and resubmit.

To help facilitate an understanding of patient origin by counties in the TN portion of the service area, please complete the table below.

Patient Origin – Erlanger Medical Center NICU Service

COUNTY	EMC Service Area Type	Births by Female Residents 2014	Infant Utilization at EMC NICU Service Units* 2014
Bledsoe*	SSA		
Bradley*	SSA		
Grundy*	SSA		
Hamilton*	PSA		
McMinn*	SSA		
Marion*	SSA		
Meigs*	SSA		
Polk*	SSA		
Rhea*	SSA		
Sequatchie*	SSA		
Coffee	TSA		
Subtotal-Southeast Perinatal Region	10 Counties		
Cumberland	TSA		
Franklin	TSA		
Loudon	TSA		
Monroe	TSA		
Roane	TSA		
Van Buren	TSA		
Warren	TSA		
Total-EMC Service Area	18 Counties		

**Note: total infant admissions or cases of EMC hospital NICU units in 2014*

Item 4.a - The table with demographic information is noted. Please revise the table by using 2016 and 2020 population data available from the Tennessee Dept. of Health and resubmit labeled as page 48-R.

Response

Item 3

Cumberland County was not omitted from the geography identified on the Tennessee Service Area map, it is difficult to identify due to the markings which identify the Tennessee Service Area. To demonstrate that Cumberland County has been identified, an unmarked Tennessee map is attached to this supplemental information so that you may compare the marked map with the unmarked map.

As requested, the table showing NICU patient origin has been completed.

Patient Origin -- Erlanger Health System NICU Service Units

County	EMC Service Area	Births By Female Residents CY 2013	Infant Utilization At EHS NICU Service Units CY 2013	Births By Female Residents CY 2014	Infant Utilization At EHS NICU Service Units CY 2014	Infant Utilization At EHS NICU Service Units CY 2015
Bledsoe (*)	SSA	109	5	119	8	14
Bradley (*)	SSA	1,241	96	1,206	81	90
Grundy (*)	SSA	177	14	151	8	12
Hamilton (*)	PSA	4,170	501	4,144	550	574
Marion (*)	SSA	315	30	324	50	49
McMinn (*)	SSA	589	11	553	6	13
Meigs (*)	SSA	136	5	102	6	2
Polk (*)	SSA	167	8	177	10	10
Rhea (*)	SSA	402	32	384	33	35
Sequatchie (*)	SSA	163	9	152	17	17
Subtotal - Southeast Perinatal Region	10 Counties	7,469	711	7,312	769	816
Coffee	TSA	661	7	693	4	8
Cumberland	TSA	527	2	548	0	0
Franklin	TSA	406	14	399	11	13
Loudon	TSA	543	1	510	0	1
Monroe	TSA	535	2	527	0	1
Roane	TSA	476	0	433	0	1
Van Buren	TSA	62	0	61	1	0
Warren	TSA	507	2	77	7	14
Total - EMC Service Area - In Tennessee	18 Counties	11,186	739	10,560	792	854

Notes
(1) CY 2013 and CY 2014 has been used for completion of this table for total births by county from the Tennessee Dept. of Health website.
(2) EHS patient origin data has also been provided for CY 2015, so that the trend in NICU utilization may be seen.

Item 4.a

As requested, the table with demographic information has been revised by using population data for 2016 and 2020

available from the Tennessee Dept. of Health. The replacement labeled as page 48-R is attached to this supplemental information.

8.) Section C, Need, Item 5.

The table identifying 3-year trend in NICU utilization of hospitals in the applicant's service area is noted. What was the source of the information used to identify the 4 hospitals with Level II or above NICU units in the 18 TN county portion of the service area? Please clarify.

What accounts for the difference in the 74.4% occupancy shown in the table for Children's Hospital @ Erlanger from 94.3% shown on page 32 in the application? If correct at 74.4%, what accounts for the significant increase in occupancy to an average of approximately 107% in 2015?

The table on page 52 labeled "General Utilization Trends "is noted. Please revise by adding a row showing licensed bed occupancy on inpatient admissions and total licensed bed patient days of care (inclusive of observation days).

As a complement to the occupancy levels of Children's Hospital @ Erlanger, and Erlanger East Hospital, please provide the number of transfers from Erlanger East Hospital to hospitals with Level III and above units for the most recent 12-month period data is available. Please also identify primary medical reasons for the transfers - e.g. low birth weight, premature, etc.

Response

The information source for utilization data pertaining to the Level II neonatal units in the service area were the *Tennessee Joint Annual* reports.

The difference in occupancy rates for the Level IV NICU at *Children's Hospital @ Erlanger* is explained by the difference in time periods which each table represents. The table on page 51 of the application which shows 74.4% occupancy is derived from the *Tennessee Joint Annual*

Reports, which apply to our fiscal year ended June 30, 2014. The table on page 32 is based on a calendar year time period which ended December 31, 2014.

The occupancy rates shown in this CON application are based on the number of NICU beds with "fixed" monitoring equipment, the occupancy rates as shown in the Tennessee Joint Annual Reports calculate occupancy based on the total number of NICU beds, including those with "mobile" monitoring equipment.

The table for *General Utilization Trends* has been revised to show occupancy which includes *Observation* patient days.

Community Hospitals -- Chattanooga, Tennessee
General Utilization Trends

	2012			2013			2014		
	Erlanger East	Memorial Hixson	Parkridge East	Erlanger East	Memorial Hixson	Parkridge East	Erlanger East	Memorial Hixson	Parkridge East
Licensed Beds	43	69	128	43	69	128	43	69	128
General Acute Care - Admissions	4,909	4,194	5,393	4,803	4,088	5,487	4,379	4,232	6,625
Inpatient Pt. Days - Acute Care	10,382	16,982	19,103	10,278	16,617	20,617	9,276	17,461	23,240
Observation Patient Days	205	1,401	2,363	572	1,491	2,396	551	1,644	2,624
Total Patient Days	10,587	18,383	21,466	10,850	18,108	23,013	9,827	19,105	25,864
General Acute Care - ALOS	2.11	4.05	3.54	2.14	4.06	3.76	2.12	4.13	3.51
Occupancy (including observation days)	67.3%	72.8%	45.8%	69.1%	71.9%	49.3%	62.6%	75.9%	55.4%
ED Visits	0	30,636	42,033	6,100	25,516	38,136	22,009	30,798	41,422
Total Surgical Patients	8,576	4,056	4,253	8,407	3,923	4,104	8,328	3,911	4,173
OB Deliveries	2,607	0	3,154	2,531	0	3,128	2,508	0	4,164

Notes
(1) For CY 2012 the occupancy is calculated based on 366 calendar days due to leap year.

Transfers from the Level II *Special Care Nursery* at *Erlanger East Hospital* to *Children's Hospital @ Erlanger* in CY 2015 was 26. The reasons for transfer are varied, but include among others … prematurity, cardiac consult, surgical consult for GI, seizures, respiratory distress and hypoxic ischemia encephalopathy.

9.) Section B, Project Description, Item II.A.

The table of general utilization trends is noted. Since the applicant opened its existing 6-bed Level II unit in 2004, please revise the table by showing the historical and projected utilization of the 6-bed unit. Please also add a row to the table that shows the projected utilization for the proposed 10-bed Level III unit in 2018, 2019 and 2020. Please submit

the revised table labeled as replacement page 52.

Please complete the table below sowing the historical and projected combined utilization of all Erlanger Medical Center NICU units.

Campus	NICU beds	Level (II or above)	Cases 2013	Cases 2014	Cases 2015	% change 13'-15'	Projected Cases 2018 (Year 1)	Projected Cases 2019 (Year 2)
Children's Hospital								
Erlanger East								
EMC Combined Total								

Response

The Level II unit at *Erlanger East Hospital* originally received CON approval by the *Agency*, formerly the *Health Facilities Commission*, with CON No. CN9405-025A. The licensed beds for the Level II unit at *Erlanger East Hospital* applicable to the Level II unit received CON approval for transfer from Erlanger Medical Center with CON No. CN0407-067A. The historical utilization for the level II unit at *Erlanger East Hospital* back to 2004 is not available. Therefore, we have provided historical data for the past 4 years which are available. As requested, a revised page 52-R is attached to this supplemental information.

As requested, the EHS combined NICU service table has been completed.

EHS -- Combined NICU Service Utilization Trend

	NICU Beds (*)	NICU Level	NICU Cases CY 2013	NICU Cases CY 2014	NICU Cases CY 2015	% Change '13 - '15	Projected Cases CY 2018 (Year 1)	Projected Cases CY 2019 (Year 2)
Children's Hospital @ Erlanger	73	IV	809	863	886	9.5%	832	832
Erlanger East Hospital	12	II	211	251	270	28.0%	536	536
Erlanger East Hospital	10	III	0	0	0	0.0%	389	389
Total -- EHS Combined NICU Service	95		1,020	1,114	1,156	13.3%	1,757	1,757

(*) NOTE -- NICU beds at project completion.

10.) Section C, Item 4 (Historical & Projected Data Charts).

The charts are noted.

Historical Data Chart – The chart submitted does not appear to correspond to the audited financial statements for Erlanger Health System provided in the attachment. Please clarify.

What accounts for the $47 million improvement in net income from a loss of approximately $24.8 million in 2012 to positive net income of $22.8 million in 2014? Please clarify.

Please provide Historical Data Charts for Erlanger East Hospital's existing 6-bed Level II unit and Erlanger Medical Center's NICU service as a whole showing the combined utilization and financial performance of the service for the 3 most recent fiscal year periods.

Projected Data Chart – Please provide a combined Projected Data Chart for Erlanger Medical Center's NICU service as a whole, showing the combined utilization and financial performance for Year 1 and Year 2 of the project.

Please complete the table below showing the historical and projected financial performance of Erlanger East Hospital.

Applicant's Historical & Projected Financial Performance

Financial Measure	Erlanger East Hospital FY 2014	Erlanger East Hospital Year 1 FY 2018	Erlanger East Hospital NICU Service Year 1 FY 2018
Patient Days			
Gross Operating Revenue			
Net Operating Revenue			
Total Operating Expenses			
EBDITA			
Depreciation			
Capital			

Expenditures			
Total Indirect Expenses			
Net Income			

Response

The improvement in financial performance for Erlanger Health System between FY 2013 and FY 2015 is explained by a concerted effort to become more efficient and execute more effectively in the operation of our hospitals. To illustrate, with an increasing number of admissions and patient days, our the number of FTE's per adjusted occupied bed has decreased from 5.4 in FY 2013 to 4.8 in FY 2015, an improvement of 11.1%. Also, Erlanger Health System now participates in, and receives funding from, the *Tennessee Supplemental Hospital Payment Pool*. This funding source helps to defray some of the cost of charitable care which *Erlanger* provides each year. Erlanger began to receive funding from this source in FY 2014.

The historical financial performance for *Erlanger East Hospital's* Level II *Special Care Nursery* has been completed.

	====== Erlanger East -- NICU Service =====		
	FY 2013	**FY 2014**	**FY 2015**
Patient Days	1,168	1,454	1,916
Gross Operating Revenue	4,506,127	5,972,594	9,487,646
Net Operating Revenue/Projected Payments	1,796,799	2,020,512	2,534,528
Total Operating Expenses/Direct Expenses	1,744,036	1,887,142	2,192,658
EBIDTA	52,763	133,370	341,870
Depreciation	7,942	7,352	6,938
Capital Expenditures	0	0	15,950
Total Indirect Expenses (not included above)	582,494	498,874	775,981
Net Income	(537,673)	(372,856)	(456,999)

Notes
(1) The indirect expenses shown in this table represent an allocation of corporate overhead.

The historical financial performance for *Erlanger's* combined NICU service has been completed.

	======= EHS -- Combined NICU's =======		
	FY 2013	FY 2014	FY 2015
Patient Days	17,254	19,466	23,212
Gross Operating Revenue	89,363,400	96,209,784	141,599,687
Net Operating Revenue/Projected Payments	38,853,718	38,303,555	53,409,680
Total Operating Expenses/Direct Expenses	13,887,257	15,403,932	17,757,412
EBIDTA	24,966,461	22,899,623	35,652,268
Depreciation	341,790	204,455	180,073
Capital Expenditures	42,434	13,250	204,530
Total Indirect Expenses (not included above)	8,905,213	8,465,908	9,292,546
Net Income	15,677,024	14,216,010	25,975,119

Notes
(1) The indirect expenses shown in this table represent an allocation of corporate overhead.

The Projected Data Chart for *Erlanger's* combined NICU service has been completed and is attached to this supplemental information.

As requested, the projected financial performance for *Erlanger East Hospital* has been completed.

=== Applicant's Historical & Projected Financial Performance ===			
	Erlanger East Hospital FY 2015	Erlanger East Hospital Year 1	Erlanger East NICU Service Year 1
Patient Days	12,811	31,881	6,770
Gross Operating Revenue	163,728,547	306,092,305	31,122,158
Net Operating Revenue/Projected Payments	42,886,558	81,173,686	8,122,354
Total Operating Expenses/Direct Expenses	28,547,262	55,532,558	5,868,444
EBIDTA	14,339,295	25,641,128	2,253,910
Depreciation	1,961,984	5,461,197	999,701
Capital Expenditures	501,147	5,151,675	1,008,713
Total Indirect Expenses (not included above)	12,931,107	13,707,088	775,981
Net Income	(1,054,943)	1,321,168	(530,485)

Notes
(1) The indirect expenses shown in this table represent an allocation of corporate overhead.

11.) Section C, Economic Feasibility, Item 5.

The response is noted. Per the Projected Data Chart, there is an average gross charge of $4,480.55 per patient day in Year 1 of the project. How does this amount compare to the $33,643 average gross charge per patient. Does it apply to the response provided in the application? Please clarify.

Response

To obtain the average gross charge per patient of $ 33,643, the average gross charge per patient day of $ 4,480.55 is multiplied by the assumed average length of stay ("ALOS"), this yields a total of $ 33,604. The difference of $ 39 is due to rounding in *Erlanger's* financial model.

12.) Section C, Economic Feasibility, Item 9.

The response is noted. Please complete the table below showing the historical payor mix of Erlanger Medical Center's NICU service as a whole and the projected payor mix of Erlanger East Hospital's NICU service in Year 1 of the project.

Response

As requested, the table showing the payor mix has been completed.

=== Combined NICU Service & Erlanger East Hospital NICU Service -- Payor Mix - Year 1 ===

Payor Source	Total Combined Gross Revenue EMC & EE NICU Service FY 2015	As A % Of Gross Revenue Year 1	Erlanger East Hospital NICU Service Gross Revenue Year 1	As A % Of Gross Revenue Year 1
Medicare	0	0%	0	0%
TennCare	94,686,652	67%	10,091,518	32%
Commercial/Managed Care	45,797,294	32%	19,944,053	64%
Self-Pay/Charity	1,115,741	1%	1,090,718	4%
Other	0	0%	0	0%
Total	141,599,687	100%	31,126,289	100%

13.) Section C, Orderly Development, Item C.

Direct patient care staffing of the proposed NICU by 14.0 full time equivalent (FTE) registered nurses and unit clerks is noted. Please describe how the following positions will be accounted for in the proposed NICU staffing plan: Board Certified Obstetrician, Board Certified Pediatrician, NICU Medical Director/Assistant Director, Nurse Manager, Respiratory Therapist and Pharmacist.

Please complete the following table showing the staffing for Erlanger Medical Center's NICU service as a whole and the projected staffing at Erlanger East Hospital in Year 1.

Response

Children's Hospital @ Erlanger is developing a system approach in order to optimize standards of practice in all of our hospitals for Pediatric's and Neonatology. Leadership at *Children's Hospital*, in collaboration with each hospital facility, will oversee the training and development of policies to achieve the highest level of care for these specialized patients.

Currently there are forty-eight 48 board certified Obstetricians, six (6) full-time and four (4) PRN board certified Neonatologists, one (1) NICU Medical Director, one (1) Women's Service Director and one (1) Assistant Nurse Manager.

As requested, the table showing the expected staffing for the NICU service at *Erlanger East Hospital* has been completed.

Applicant's Proposed Clinical Staffing Plan, Year 1

Position Type	Erlanger East Hospital NICU Service Year 1	Erlanger Med Center NICU Service (Combined) Year 1
Nurse Practitioner	4.5 FTE	16.5 FTE
Registered Nurse	32.98 FTE	134 FTE

Respiratory Therapist	9.57 FTE total RT -	10 FTE's dedicated to Children's NICU, total overall 19.57
Pharmacist	4 FTE	13 FTE
Other - Clinical	0	0
Total	**51.05**	**183.07**

SUPPLEMENTAL #1
January 26, 2016
9:00 am

A F F I D A V I T

STATE OF TENNESSEE |
|
COUNTY OF HAMILTON |

NAME OF FACILITY Erlanger East Hospital

I, Joseph M. Winick, after first being duly sworn, State under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

SIGNATURE

SWORN to and subscribed before me this 25 of January (Month), 2016 (Year), a Notary Public in and for the State of Tennessee, County of Hamilton.

Shelia Hall
NOTARY PUBLIC

My commission expires June 9 (Month / Day), 2018.

SHELIA HALL
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY

SUPPLEMENTAL #1

January 26, 2016
9:00 am

TABLE OF ATTACHMENTS

SUPPLEMENTAL #1
January 26, 2016
9:00 am

Description

EHS – Service Area For NICu Service
Unmarked Map Of Tennessee For Service Area Verification
Revised – square Footage & Cost Per Square Footage Chart
CON Application - Replacement Page 48
CON Application - Replacement Page 52
Projected Data Chart – EHS Combined NICU Service
NICU Medical Director Letter
NICU Medical Director CV
Neonatologist Medical Licenses
Neonatology Medical Contract With Pediatrix Medical Group

SUPPLEMENTAL #1

January 26, 2016
9:00 am

ATTACHMENTS

SUPPLEMENTAL #1
January 26, 2016
9:00 am

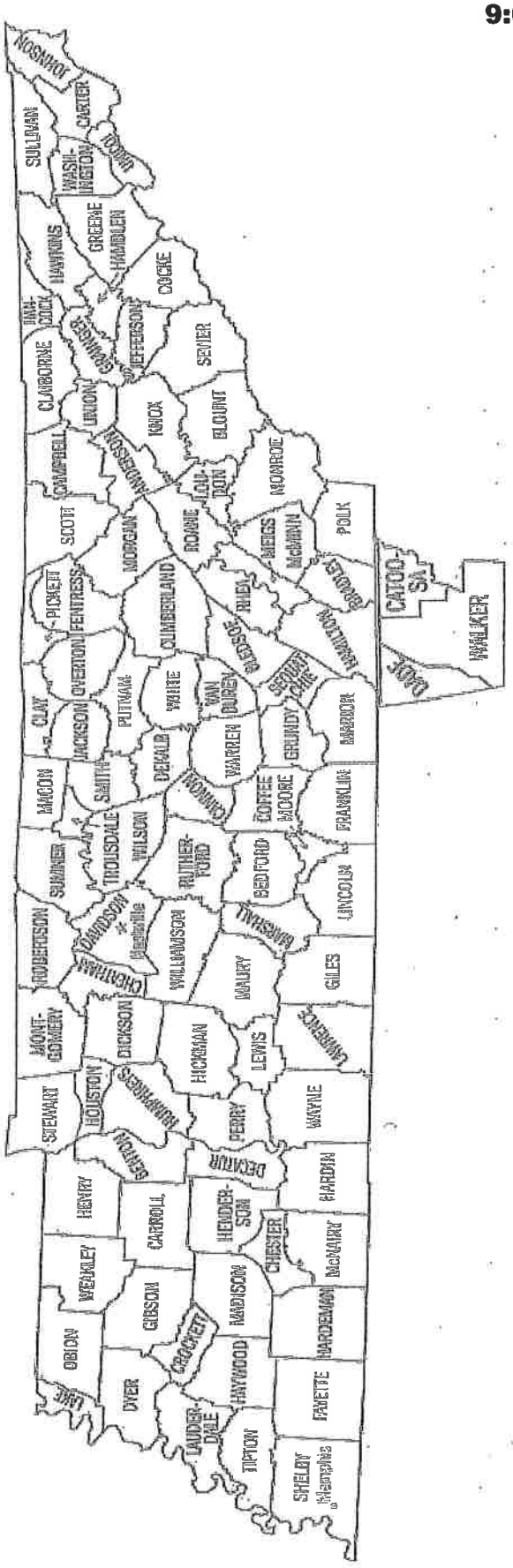
Erlanger Health System
Service Area For NICU Service Line

County	State	Service Area	Tennessee Perinatal Region
Hamilton	TN	PSA	Southeast
Bledsoe	TN	SSA	Southeast
Bradley	TN	SSA	Southeast
Grundy	TN	SSA	Southeast
Marion	TN	SSA	Southeast
McMinn	TN	SSA	Southeast
Meigs	TN	SSA	Southeast
Polk	TN	SSA	Southeast
Rhea	TN	SSA	Southeast
Sequatchie	TN	SSA	Southeast
Catoosa	GA	SSA	
Dade	GA	SSA	
Walker	GA	SSA	
Dekalb	AL	TSA	
Jackson	AL	TSA	
Chattooga	GA	TSA	
Fannin	GA	TSA	
Gilmer	GA	TSA	
Gordon	GA	TSA	
Murray	GA	TSA	
Whitfield	GA	TSA	
Cherokee	NC	TSA	
Coffee	TN	TSA	Middle
Cumberland	TN	TSA	East
Franklin	TN	TSA	Middle
Loudon	TN	TSA	East
Monroe	TN	TSA	East
Roane	TN	TSA	East
Van Buren	TN	TSA	Middle
Warren	TN	TSA	Middle

SUPPLEMENTAL #1

January 26, 2016

9:00 am



Square Footage & Cost Per Square Footage Chart

A. - Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	= Proposed Final Square Footage = Renovated	New	Total	== Proposed Final Cost Per SF === Renovated	New	Total
Erlanger East - Level 3 NICU	N / A	0	N / A	2nd Floor -	0	8,805	8,805	0.00	403.38	3,551,753
B. - Unit/Dept. GSF - Sub-Total								0.00	403.38	3,551,753
C. - Mechanical/Electrical GSF					Included	Included				
D. - Circulation/Construction GSF					Included	Included				
E. - Total GSF		0			0	8,805	8,805	0.00	403.38	3,551,753

SUPPLEMENTAL #1
January 26, 2016
9:00 am

SUPPLEMENTAL #1
January 26, 2016
9:00 am

Information pertaining to the neonatal patient group is within the age cohort of those 0-4 years of age. As such, this age cohort decreased from 87,476 to 84,736 between 2010 and 2015, or 3.1%. However, the growth rate between 2015 and 2019 is expected to grow by 515, or 0.6%. This represents an inflection point in the demographics of the service area for the 0-4 age group, and this age cohort likely will continue to experience additional growth.

A summary of other demographic information is also presented which outlines changes in population, *TennCare* enrollment and population below the Federal poverty level for each county within of the service area that is located in Tennessee.

	Hamilton	Bradley	Marion	Grundy	Sequatchie	Bledsoe		
Current Year (2016) - Age 65+	61,073	17,879	5,763	3,021	3,195	2,628		
Projected Year (2020 - Age 65+	69,752	20,381	6,584	3,339	3,896	2,955		
Age 65+ - % Change	14.2%	14.0%	14.2%	10.5%	21.9%	12.4%		
Age 65+ - % Total	17.1%	16.9%	20.2%	22.4%	20.2%	19.8%		
Total Pop. - 2016	356,156	105,549	28,585	13,470	15,835	13,273		
Total Pop. - 2020	368,666	109,706	28,633	13,263	16,943	13,481		
Total Pop. - % Change	3.5%	3.9%	0.2%	-1.5%	7.0%	1.6%		
Median Age	39	38	42	41	41	42		
Median Household Income	$46,702	$41,083	$41,268	$26,814	$36,434	$33,443		
TennCare Enrollees	61,399	20,321	6,636	4,626	3,716	3,082		
TennCare Enrollees As % Of Total Pop.	17.2%	19.3%	23.2%	34.3%	23.5%	23.2%		
Persons Below Poverty Level	59,979	20,664	5,215	3,957	2,653	2,825		
Persons Below Poverty Level As % Of Total Pop.	16.8%	19.6%	18.2%	29.4%	16.8%	21.3%		
	Rhea	Meigs	McMinn	Polk	Franklin	Coffee		
Current Year (2016) - Age 65+	6,589	2,677	11,089	3,680	8,752	10,225		
Projected Year (2020 - Age 65+	7,571	3,151	12,650	4,134	9,972	11,573		
Age 65+ - % Change	14.9%	17.7%	14.1%	12.3%	13.9%	13.2%		
Age 65+ - % Total	19.4%	21.9%	20.4%	21.1%	20.8%	18.3%		
Total Pop. - 2016	33,934	12,221	54,449	17,442	42,097	55,932		
Total Pop. - 2020	35,216	12,462	55,724	17,812	42,681	57,865		
Total Pop. - % Change	3.8%	2.0%	2.3%	2.1%	1.4%	3.5%		
Median Age	40	43	42	43	41	40		
Median Household Income	$36,741	$35,150	$39,410	$39,074	$42,904	$37,618		
TennCare Enrollees	8,490	2,907	11,270	3,784	7,166	12,252		
TennCare Enrollees As % Of Total Pop.	25.0%	23.8%	20.7%	21.7%	17.0%	21.9%		
Persons Below Poverty Level	7,631	2,553	9,786	2,867	6,250	11,457		
Persons Below Poverly Level As % Of Total Pop.	22.5%	20.9%	18.0%	16.4%	14.8%	20.5%		
	Warren	Van Buren	White	Monroe			Service Area	State Of Tennessee
Current Year (2016) - Age 65+	40,872	5,651	27,519	47,980			258,593	1,012,937
Projected Year (2020 - Age 65+	41,446	5,686	28,541	50,062			281,693	1,134,565
Age 65+ - % Change	1.4%	0.6%	3.7%	4.3%			8.9%	12.0%
Age 65+ - % Total	556.1%	430.4%	474.0%	461.4%			33.4%	15.2%
Total Pop. - 2016	7,350	1,313	5,806	10,398			773,810	6,649,438
Total Pop. - 2020	8,233	1,554	6,751	12,384			801,374	6,894,997
Total Pop. - % Change	12.0%	18.4%	16.3%	19.1%			3.6%	3.7%
Median Age	39	45	42	42				38
Median Household Income	$34,641	$33,547	$34,474	$37,595			$45,482	$44,298
TennCare Enrollees	10,217	1,242	6,574	10,881			174,563	1,331,838
TennCare Enrollees As % Of Total Pop.	139.0%	94.6%	113.2%	104.6%			22.6%	20.0%
Persons Below Poverty Level	8,742	1,222	5,399	9,126			160,326	1,170,301
Persons Below Poverty Level As % Of Total Pop.	118.9%	93.1%	93.0%	87.8%			20.7%	17.6%

Community Hospitals -- Chattanooga, Tennessee
General Utilization Trends

	2012			2013			2014		
	Erlanger East	Memorial Hixson	Parkridge East	Erlanger East	Memorial Hixson	Parkridge East	Erlanger East	Memorial Hixson	Parkridge East
General Acute Care - Admissions	4,909	4,194	5,393	4,803	4,088	5,487	4,379	4,232	6,625
Inpatient Pt. Days - Acute Care	10,382	16,982	19,103	10,278	16,617	20,617	9,276	17,461	23,240
General Acute Care - ALOS	2.11	4.05	3.54	2.14	4.06	3.76	2.12	4.13	3.51
ED Visits	0	30,636	42,033	6,100	25,516	38,136	22,009	30,798	41,422
Total Surgical Patients	8,576	4,056	4,253	8,407	3,923	4,104	8,328	3,911	4,173
OB Deliveries	2,607	0	3,154	2,531	0	3,128	2,508	0	4,164

NOTES
(1) This information is derived from *Tennessee Joint Annual Reports*.

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.

Response

Utilization data for *Erlanger East Hospital* is presented below.

Erlanger East Hospital
General Utilization Trends

					Projected Utilization				
	2012	2013	2014	2015	2016	2017	2018	2019	2020
General Acute Care - Admissions	2,840	2,709	2,640	2,908	2,930	2,952	2,973	2,995	3,017
Inpatient Pt. Days - Acute Care	6,406	6,161	5,690	6,378	6,426	6,473	6,521	6,569	6,616
General Acute Care - ALOS	2.26	2.27	2.16	2.19	2.19	2.19	2.19	2.19	2.19
ED Visits	0	6,100	22,008	26,172	24,748	25,367	26,001	26,651	27,317
Total Surgical Patients	3,182	3,183	3,262	3,527	3,282	3,306	3,331	3,355	3,379
OB Deliveries	2,619	2,553	2,508	2,592	2,619	2,638	2,657	2,677	2,696
Special Care Nursery - Level II *(Cases)*	189	211	251	270	287	304	322	322	322
NICU - Level III *(Cases)*	0	0	0	0	0	0	389	389	389

NOTES
(1) This information is derived from the internal records of *Erlanger Health System*.
(2) The trends outlined are based on historical trends. Upon completion of the expansion project at *Erlanger East Hospital* (no. CN0407-047), utilization will be higher.

The projected utilization is based upon a use rate average calculation for the four (4) year period of 2012 - 2015. Expected growth could exceed this forecast based on

SUPPLEMENTAL #1

January 26, 2016
9:00 am

PROJECTED DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in July (Month).

		Year 1	Year 2
A.	Utilization Data	27,957	27,957
	(Specify Unit Of Measure) NICU Patient Days		
B.	Revenue From Services To Patients		
	1. Inpatient Services	163,234,199	164,251,021
	2. Outpatient Services		
	3. Emergency Services		
	4. Other Operating Revenue		
	Gross Operating Revenue	163,234,199	164,251,021
C.	Deductions From Operating Revenue		
	1. Contractual Adjustments	90,685,917	91,499,630
	2. Provision For Charity Care	12,508,403	12,620,639
	3. Provision For Bad Debt	1,042,372	1,051,725
	Total Deductions	104,236,692	105,171,994
	NET OPERATING REVENUE	58,997,507	59,079,027
D.	Operating Expenses		
	1. Salaries And Wages	16,952,142	17,051,370
	2. Physician's Salaries And Wages		
	3. Supplies	2,533,748	2,543,885
	4. Taxes		
	5. Depreciation	1,172,836	1,172,836
	6. Rent		
	7. Interest - Other Than Capital		
	8. Management Fees:		
	a. Fees To Affiliates		
	b. Fees To Non-Affiliates		
	9. Other Expenses	11,239,909	11,229,301
	(Specify) Purchased Svcs, Marketing, Drugs, OH Allocation		
	Total Operating Expenses	31,898,635	31,997,393
E.	Other Revenue (Expenses) – Net		
	(Specify)		
	NET OPERATING INCOME (LOSS)	27,098,872	27,081,634
F.	Capital Expenditures		
	1. Retirement Of Principal		
	2. Interest	1,197,239	1,197,239
	Total Capital Expenditures		
	NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	25,901,633	25,884,395

SUPPLEMENTAL #1
January 26, 2016
9:00 am

PEDIATRIX MEDICAL GROUP

January 22, 2016

Lisa A. Lowery-Smith, M.D.
Medical Director
Gary L. Bell, M.D.
W. Woods Blake, M.D.
Mari A. Eaton, M.D.
Kathryn W. Huddleston, M.D.
Nicholas C. Sherrow, M.D.
Kristen M. Turner, M.D.
Agnieszka A. Wesolowski, M.D.

To whom it may concern:

As Southeast Tennessee's Regional Neonatal representative to the state Perinatal Advisory Committee, and as Medical Director of Erlanger Health Systems' two Neonatal Intensive Care Units, I am writing in support of initiatives that will help Erlanger better meet our region's growing need for Neonatology services. Our Level 4 Regional NICU at Children's Hospital, located on the main Baroness Erlanger campus in downtown Chattanooga, has been at or above patient bed capacity with increasing frequency over the past two years. Unfortunately, Children's is constrained from adding adequate numbers of new NICU beds to fully meet demand by inadequate space for expansion. The lack of beds places newborns from our region requiring neonatal services at increased risk of transport far from their homes to distant facilities. Our Erlanger East campus offers a solution to the problem if current proposals to increase the number of neonatal beds as well as to change the level of designated care from Special Care Nursery (SCN) to Level 3 NICU at that facility are approved.

The NICU at Erlanger East already provides care for neonates born at 34 weeks or greater gestational age. Services include short term ventilation, less aggressive respiratory support, intravenous nutrition and/or antibiotic therapy, and management of neonatal abstinence. The unit is staffed with a 24/7/365 neonatal nurse practitioner and with both neonatal trained registered nurses and dedicated pediatric respiratory therapists. A board-certified or board-eligible neonatologist performs daily onsite rounds and provides 24-hour on call availability.

The proposed expansion at Erlanger East will transform the current six bed Special Care Nursery into a twelve bed Level 2 NICU and a ten bed Level 3 NICU. The ten bed Level 3 unit will consist of individual private rooms allowing for optimum family-centered care. The same neonatal coverage model as described above will continue. Additionally, pediatric subspecialists from the main Baroness Erlanger Children's' campus will be available to provide onsite or remote coverage as required. We anticipate infrequent transfers to the Level 4 unit on the main campus due to the level of care the East Level 2 and 3 NICU will provide.

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In summary, expansion of the existing Special Care Nursery at the Erlanger East Campus, combined with new designations as higher level neonatal intensive care units, will greatly enhance delivery of Neonatology services throughout the region, decrease overcrowding at the main campus of Children's NICU at the Baroness Erlanger Campus, and reduce risk of transport to remote facilities far removed from patients' homes. I strongly urge approval of proposals to increase the number of neonatal beds and to raise the designated level of care of Erlanger East's NICU to Level 3.

Sincerely,

Lisa Lowery-Smith, M.D.

Medical Director, NICU

Erlanger Medical Center

SUPPLEMENTAL #1
January 26, 2016
9:00 am

CURRICULUM VITAE

NAME: Lisa A. Lowery-Smith, M.D.

HOME ADDRESS: 7821 Night Hawk Road
Chattanooga, Tennessee 37421

EDUCATION:

High School/Undergraduate:
Arab High School, Arab, Alabama
September, 1975 - May, 1979

Undergraduate:
University of Tennessee, Chattanooga, Tennessee
August, 1979 - May, 1983
Degree - B.A., Biology (minor: Chemistry)
Magna Cum Laude

Graduate:
University of South Alabama College of Medicine
Mobile, Alabama
September, 1983 - June, 1987
Degree M.D.

Postgraduate: Intership - Categorical Pediatrics
University of South Alabama Medical Center
Mobile Alabama
July, 1987 - June 1988

Residency:
Pediatrics, University of South Alabama Medical Center
Mobile, Alabama
July 1988 - June 1990

Fellowship:
Neonatal-Perinatal Medicine
University of Tennessee
Center for Health Sciences
Memphis, Tennessee
July 1990 - June 1993

BOARD CERTIFICATION:

National Board of Medical Examiners, July, 1988
American Board of Pediatrics, November, 1990
Sub-Board of Neonatal-Perinatal Medicine, November, 1995
October, 2014 successfully completed Maintenance of Certification Cycle 1/1/2010 – 12/31/2014
Active Enrollment for Maintenance of Certification cycle 11/25/2014 – 12/31/2019

LICENSURE:

Alabama	14166	June, 1988
Tennessee	MD024491	May, 1993
Georgia	040951	October, 1995

SOCIETY MEMBERSHIPS:

American Academy of Pediatrics
American Academy of Pediatrics – Section on Perinatal Pediatrics Fellow
National Perinatal Association
Tennessee Perinatal Association

TEACHING EXPERIENCE:

American Heart Association, Neonatal Advanced Life Support
1989 - Present
University of Tennessee, Memphis, Tennessee, Graduate Nurse Masters Program
Neonatal Respiratory Physiology and Pathophysiology
19 Hours 1992 - 1993

HONORS:

University of Tennessee
Chattanooga, Tennessee
UC Foundation Chancellor's
Student Athelete-Scholar
1979 - 1983

University of Tennessee
Chattanooga, Tennessee
Joyce Litchford Memorial Scholarship
for Outstanding Biology Pre-Med Major
1982 - 1983

PUBLICATIONS (JOURNALS):

Lowery-Smith L, Mirro R, Hsu P, Leffler CW: Bradykinin increases cerebral vascular endothelial inositol phosphate turnover and prostacyclin synthesis in newborn pigs. Pediatric Research, 31 (4) 210A (#1243), 1992. Presented before the American Pediatric Society/ Society for Pediatric Research meeting in Baltimore, Md., May, 1992 (Poster).

Mirro R., Lowery-Smith L, Armstead WM, Shibata M, Zuckerman SL, Leffler CW: Hypocapneic cerebral vasoconstriction is maintained post ischemia/reperfusion in newborn pigs. Pediatric Research, 31 (4) 212A (#1260), 1992. Presented (C.W. Leffler) before the American Pediatric Society / Society for Pediatric Research meeting in Baltimore, Md., May 1992 (Poster).

Mirro R, Lowery-Smith L, Armstead WM, Shibata M, Zuckerman SL, Leffler CW: Cerebral vasoconstriction in response to hypocapnia is maintained after ischemia/reperfusion injury in newborn pigs. Stroke 1992;23: 1613 - 1616.

Lowery-Smith L, Mirro R, Hsu P, Leffer CW: Bradykinin increases cerebral vascular endothelial inositol phosphate turnover and prostacyclin synthesis in newborn pigs. The FASEB Journal, 7 (3) A334 (#1936), 1993. Presented before the Federation of American Societies for Experimental Biology/Experimental Biology meeting in New Orleans, La, March 1993 (Poster).

Albuquerque ML, Lowery-Smith L, Hsu P, Leffler CW: Increased pH stimulates inositol phosphate turnover in piglet cerebral microvascular smooth muscle cells. The FASEB Journal, 7 (3) A530 (#3076), 1993. Presented (ML Albuquerque) before the Federation of American Societies for Experimental Biology/Experimental Biology meeting in New Orleans, La, March 1993.

Albuquerque MLC, Lowery-Smith L, Hsu P, Leffler CW: Newborn piglet cerebral microvascular smooth muscle cells generate inositol phosphate turnover in response to increased Ph. Pediatric Research, 33 (4) 199A (#1178) 1993. Presented (MLC Albuquerque) before the American Pediatric Society/Society for Pediatric Research meeting in Washingtn, DC, May 1993.

Lowery-Smith L, Hsu P, Mirro R, Albuquerque MLC, Leffler CW: Bradykinin stimulation of inositol phosphate turnover and PGI2 synthesis in newborn pig cerebral microvascular endothelial cells. Pediatric Research, 33 (4) 223A (#1322) 1993. Presented before the American Pediatric Society/Society for Pediatric Research meeting in Washington, DC, May 1993 (Poster).

PRESENTATION:

Reye's Syndrome: Pediatric Grand Rounds, University of South Alabama, June, 1989.

Congenital Infections: Pediatric Grand Rounds, University of South Alabama, June, 1990.

Group B Streptococcal Infections During Pregnancy and in the Newborn: Focus on the Future, ANHONN, Tennessee State Conference, May, 1997.

COMMITTEES:

Chattanooga-Hamilton County Child Fatality Review Team	2003 - Present
MQIC Committee, Children's Hospital at Erlanger	2010 - Present
CLABSI, Physician Champion	2009 - Present
Fetal Infant Mortality Review Committee	2009 - Present

PRACTICE (PROFESSIONAL) EXPERIENCE:

Neonatologist
East Ridge Hospital
Chattanooga, Tennessee
July, 1993 – October, 2011

Neonatologist
Regional Perinatal Neonatal Associates
Chattanooga, Tennessee
July, 1995 – April, 1999

Medical Director
Parkridge East Hospital, NICU
Chattanooga, Tennessee
July, 2001 – October, 2011

Neonatologist
Pediatrix Medical Group of Tennessee
Chattanooga, Tennessee
May, 1999 – Present

Corporate Medical Director
Pediatrix Medical Group of TN
Chattanooga, Tennessee
2004-Present

Medical Director
Childrens Hospital at Erlanger
Neonatal Intensive Care Unit

Chattanooga, Tennessee
2014-Present

Medical Director
Skyridge Medical Center
NICU
Cleveland, Tennessee
September, 2010 - Present

STATE OF TENNESSEE
DIVISION OF HEALTH RELATED BOARDS

SUPPLEMENTAL #1

EXPIRATION DATE | LICENSE NO. | RENEWAL NO.
12/31/2016 | MD0000015462 | 795766

January 26, 2016
9:00 am

THIS IS TO CERTIFY THAT:
GARY L BELL MD
IS A DULY LICENSED
MEDICAL DOCTOR
IN THE STATE OF TENNESSEE AS REQUIRED BY THE TENNESSEE CODE ANNOTATED.

Rosemarie Otto
DIRECTOR, HEALTH RELATED BOARDS — SIGNATURE

GARY L BELL MD
975 EAST THIRD STREET
BOX 159
CHATTANOOGA TN 37403

937225

Renewal No.
795766

State of Tennessee
Division Of Health Related Boards

License No.
MD0000015462

This Certifies that

GARY L BELL, MD

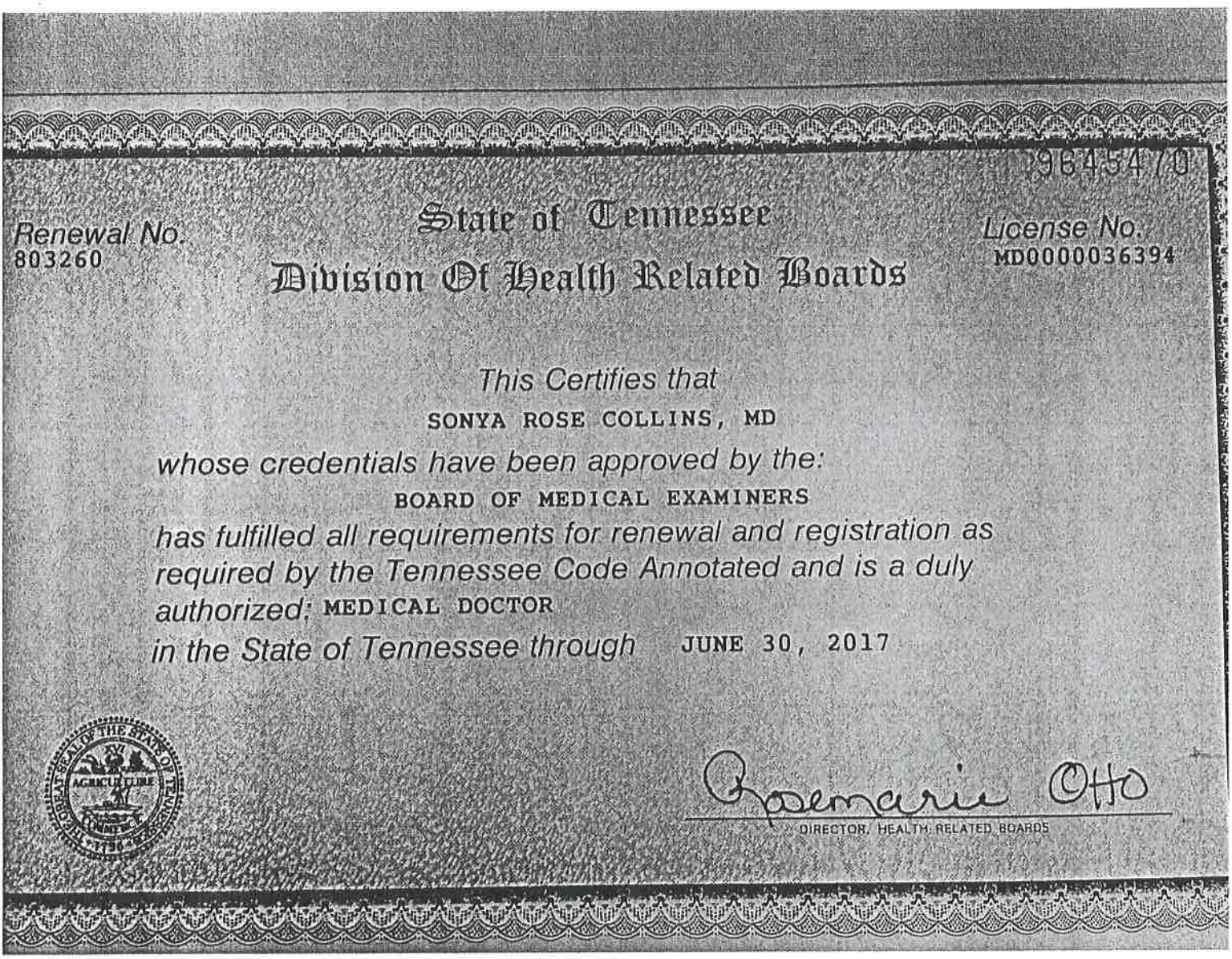
whose credentials have been approved by the:

BOARD OF MEDICAL EXAMINERS

has fulfilled all requirements for renewal and registration as required by the Tennessee Code Annotated and is a duly authorized: **MEDICAL DOCTOR**

in the State of Tennessee through **DECEMBER 31, 2016**

Rosemarie Otto
DIRECTOR, HEALTH RELATED BOARDS



964540

Renewal No.
803260

State of Tennessee
Division Of Health Related Boards

License No.
MD0000036394

This Certifies that

SONYA ROSE COLLINS, MD

whose credentials have been approved by the:

BOARD OF MEDICAL EXAMINERS

has fulfilled all requirements for renewal and registration as required by the Tennessee Code Annotated and is a duly authorized: MEDICAL DOCTOR

in the State of Tennessee through JUNE 30, 2017

Rosemarie Otto

DIRECTOR, HEALTH RELATED BOARDS

Renewal No.
785579

State of Tennessee
Division Of Health Related Boards

License No:
MD0000047189

This Certifies that

MADELEINE DEL PORTILLO, MD

whose credentials have been approved by the:

BOARD OF MEDICAL EXAMINERS

has fulfilled all requirements for renewal and registration as required by the Tennessee Code Annotated and is a duly authorized: MEDICAL DOCTOR

in the State of Tennessee through FEBRUARY 29, 2016

DIRECTOR, HEALTH RELATED BOARDS

DCF0 14 14024

SUPPLEMENTAL #1
January 26, 2016
9:00 am

Style #62007X 1-888-860-9120

9820337

State of Tennessee
Division Of Health Related Boards

Renewal No.
807443

License No.
MD0000049573

This Certifies that

MARI AFANADOR EATON, MD

whose credentials have been approved by the:

BOARD OF MEDICAL EXAMINERS

has fulfilled all requirements for renewal and registration as required by the Tennessee Code Annotated and is a duly authorized: MEDICAL DOCTOR

in the State of Tennessee through OCTOBER 31, 2017

DIRECTOR, HEALTH RELATED BOARDS

DC5014 15285

SUPPLEMENTAL #1
January 26, 2016
9:00 am

STATE OF TENNESSEE
DIVISION OF HEALTH RELATED BOARDS

SUPPLEMENTAL #1

EXPIRATION DATE: 11/30/2017
LICENSE NO: MD0000050016 795764

January 26, 2016
9:00 am

THIS IS TO CERTIFY THAT:
KATHRYN W HUDDLESTON MD
IS A DULY LICENSED
MEDICAL DOCTOR
IN THE STATE OF TENNESSEE AS REQUIRED BY THE TENNESSEE CODE ANNOTATED.

Rosemarie Otto
DIRECTOR, HEALTH RELATED BOARDS

SIGNATURE

KATHRYN WELCH HUDDLESTON MD
2920 BRALY PLACE
CHATTANOOGA TN 37415-5953

Renewal No. 95764

9372370

State of Tennessee
Division Of Health Related Boards

License No. MD0000050016

This Certifies that

KATHRYN WELCH HUDDLESTON, MD

whose credentials have been approved by the:

BOARD OF MEDICAL EXAMINERS

has fulfilled all requirements for renewal and registration as required by the Tennessee Code Annotated and is a duly authorized: **MEDICAL DOCTOR**

in the State of Tennessee through **NOVEMBER 30, 2017**

Rosemarie Otto
DIRECTOR, HEALTH RELATED BOARDS

SUPPLEMENTAL #1

January 26, 2016
9:00 am

9679747

State of Tennessee

Renewal No.
804012

License No.
MD0000024491

Division Of Health Related Boards

This Certifies that

LISA ANN LOWERY-SMITH, MD

whose credentials have been approved by the:

BOARD OF MEDICAL EXAMINERS

has fulfilled all requirements for renewal and registration as required by the Tennessee Code Annotated and is a duly authorized: MEDICAL DOCTOR

in the State of Tennessee through JULY 31, 2017

DIRECTOR, HEALTH RELATED BOARDS

014 15189

DIVISION OF HEALTH RELATED BOARDS

SUPPLEMENTAL #1

EXPIRATION DATE 02/29/2016 LICENSE NO. RENEWAL NO.

January 26, 2016

THIS IS TO CERTIFY THAT **9:00 am**

NICHOLAS C SHERROW MD

IS A DULY LICENSED

MEDICAL DOCTOR

IN THE STATE OF TENNESSEE AS REQUIRED BY THE TENNESSEE CODE ANNOTATED.

Rosemarie Otto
DIRECTOR, HEALTH RELATED BOARDS

SIGNATURE

NICHOLAS CHARLES SHERROW MD
2722 ENCLAVE BAY DR
CHATTANOOGA TN 37415-5665

Renewal No.
787703

State of Tennessee
Division Of Health Related Boards

9024854
License No.
MD0000047634

This Certifies that

NICHOLAS CHARLES SHERROW, MD

whose credentials have been approved by the:

BOARD OF MEDICAL EXAMINERS

has fulfilled all requirements for renewal and registration as required by the Tennessee Code Annotated and is a duly authorized: MEDICAL DOCTOR

in the State of Tennessee through FEBRUARY 29, 2016

Rosemarie Otto
DIRECTOR, HEALTH RELATED BOARDS

STATE OF TENNESSEE
DIVISION OF HEALTH RELATED BOARDS

SUPPLEMENTAL

EXPIRATION DATE: 06/30/2017 LICENSE NO.: MD0000 RENEWAL NO.: **January 26, 2016**

THIS IS TO CERTIFY THAT **9:00 am**
KRISTEN M SORROW TURNER MD
IS A DULY LICENSED
MEDICAL DOCTOR
IN THE STATE OF TENNESSEE AS REQUIRED BY THE TENNESSEE CODE ANNOTATED.

Rosemarie Otto
DIRECTOR, HEALTH RELATED BOARDS — SIGNATURE

SORROW TURNER, KRISTEN MELINDA
6408 FOREST PARK DRIVE
SIGNAL MOUNTAIN TN 37377-2814

9586875

Renewal No. 801901

State of Tennessee
Division Of Health Related Boards

License No. MD0000050149

This Certifies that

KRISTEN MELINDA SORROW TURNER, MD

whose credentials have been approved by the:

BOARD OF MEDICAL EXAMINERS

has fulfilled all requirements for renewal and registration as required by the Tennessee Code Annotated and is a duly authorized: MEDICAL DOCTOR

in the State of Tennessee through JUNE 30, 2017

Rosemarie Otto
DIRECTOR, HEALTH RELATED BOARDS

15134

SUPPLEMENTAL #1

January 26, 2016
9:00 am

SUPPLEMENTAL #1
January 26, 2016
9:00 am

NEONATOLOGY AGREEMENT

THIS NEONATOLOGY AGREEMENT (the "Agreement") is entered into as of the latest of the signature dates indicated below (the "Effective Date") by and between CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY D/B/A ERLANGER HEALTH SYSTEM (the "Erlanger") and PEDIATRIX MEDICAL GROUP OF TENNESSEE, P.C., a Tennessee professional corporation (the "Contractor").

RECITALS

WHEREAS, Erlanger owns and operates T.C. Thompson Children's Hospital, located at 910 Blackford Street, Chattanooga, TN 37403 ("T.C. Thompson") and Erlanger East Hospital, located at 1755 Gunbarrel Road, Chattanooga, TN 37421 ("Erlanger East"; collectively, T.C. Thompson and Erlanger East shall be referred to as the "Facility"); and

WHEREAS, Facility provides neonatology services when necessary and appropriate with respect to newborns ("Neonatology Services"); and

WHEREAS, the Contractor is a professional corporation that employs or otherwise engages licensed physicians and other appropriately trained personnel to provide professional medical services in the specialty of neonatology; and

WHEREAS, Erlanger desires the Contractor to be the non-exclusive primary source of certain management and administrative services relating to neonatal care at Facility and to arrange for licensed physicians to provide Neonatology Services at Facility; and

WHEREAS, the Contractor desires to provide the services described herein for Erlanger in accordance with the terms and conditions of this Agreement.

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, and other good and valuable consideration, the sufficiency of which is hereby acknowledged, the parties hereby agree as follows:

1. Scope of Services.

1.1 Neonatology Services. During the term of this Agreement, the Contractor shall be the primary non-exclusive provider of Neonatology Services at the Facility and shall provide such Neonatology Services through an appropriate number of Specialists (as defined in Section 2.1). Without limiting the generality of the foregoing, Contractor, through its employees or independent contractors, shall:

1.1.1 Provide coverage and services as set forth in Section 1.2.

1.1.2 Consult with other physicians on the Facility's medical staff, as reasonably required.

1.1.3 Assist in the development and implementation of appropriate policies and procedures for the neonatal intensive care units at the Facility (collectively, the "NICU") and for Facility's other departments providing neonatology care to newborns.

1.1.4 Assist Erlanger in complying with all of The Joint Commission standards applicable to the NICU and other departments of Facility providing neonatology care to newborns.

1.1.5 Participate in the development and presentation of educational seminars for registered nurses and other professional personnel with regard to care for newborns.

1.1.6 Develop and conduct community outreach programs relating to neonatology medical care, as reasonably requested by Erlanger.

1.2 Coverage, Scheduling. The Contractor shall arrange for the provision of all Neonatology Services at the Facility twenty-four (24) hours a day, seven (7) days a week, including holidays, by a sufficient number of Specialists as is mutually acceptable to Erlanger and Contractor, which services shall be provided at T.C. Thompson on an in-house basis and at Erlanger East on an on-call basis. The parties further agree that Contractor shall be available to provide Neonatology Services to infants requiring transfer to the Facility ("Transport Services") twenty-four (24) hours a day, seven (7) days a week, including holidays. The Contractor shall establish staffing and coverage schedules acceptable to Erlanger to ensure appropriate coverage, including in-house and on-call schedules. Contractor shall ensure that a sufficient number of physicians qualifying as Specialists are available to supervise the Contractor's nurse practitioners providing services herein as appropriate.

1.2.1 Specialists shall: (a) be the primary non-exclusive providers of Neonatology Services in the NICU; (b) be available to perform procedures and consultations with respect to newborns; (c) attend high-risk cesarean sections and deliveries when necessary and appropriate and in keeping with applicable standards of care; and (d) coordinate transport of infants as part of Erlanger's transport team and provide Transport Services when attending transported patients.

1.2.2 Contractor agrees to staff all shifts with sufficient and appropriate personnel to safely provide needed care according to the number and acuity of patients in the NICU, and the expected acuity level within the NICU on that shift. Contractor further agrees to make every effort to respond promptly and effectively to any concerns raised by Erlanger if staffing ratios are in question.

1.3 Applicable Standards. The Contractor shall arrange for Neonatology Services to be provided to Erlanger in a manner that will ensure that all duties are performed and services provided in accordance with any applicable standard, ruling or regulation of The Joint Commission, the Department of Health and Human Services, or any other federal, state, or local government agency exercising authority with respect to or affecting Erlanger. Specialists shall provide Neonatology Services consistent with the facilities and equipment available, and in accordance with the prevailing professional standard of care. Contractor acknowledges that

Erlanger is accredited by The Joint Commission and that Erlanger will evaluate the services provided by Contractor for quality and patient safety as an integral part of the decision to renew the Agreement. Contractor shall abide by, and shall require all Specialists to abide by, (a) Erlanger's Code of Conduct and Ethics (a copy of which is available online at http://www.erlanger.org/workfiles/CodeOfConduct[1].011906.pdf), (b) Erlanger's Stark and Anti-Kickback policy (a copy of which is available online at http://www.erlanger.org/workfiles/StarkAnti_Kickback%20Policy.Adm.980.NEW.09212010.doc.pdf), and (c) Erlanger's Compliance Program (a copy of which is available online at http://www.erlanger.org/workfiles/EHS%20Compliance%20Program%20Plan-2011.pdf), each of which is incorporated herein by this reference. Contractor shall further require all Specialists and any other employees, independent contractors or agents providing Neonatology Services hereunder to abide by the same, including participation in any compliance training as may be requested by Erlanger.

1.4 Quality Improvement. Contractor and its Specialists shall abide by all quality standards and initiatives implemented or requested by the Senior Vice President of Children's Services at Erlanger, or his/her designee (in the event Erlanger has notified Contractor in writing of such designation) and the Medical Director (as defined in Section 5.4). Contractor will participate in a national neonatal database such as the Vermont Oxford Database or like entity (to be agreed upon by Contractor and Erlanger), in order to compare local outcomes data to a national benchmark. Information obtained from such database will then be used to identify areas of local concern whereby Contractor and Erlanger would then engage process improvement initiatives to address such concerns. Thresholds of concern whereby a process improvement is triggered may vary according to indicator and study size, but will be mutually agreed upon by Contractor and Erlanger. Erlanger reserves the right to initiate a quality improvement project involving Contractor at any time a significant need is identified. Contractor will report to Erlanger quarterly the database outcomes data as well as the status of quality care and process improvement initiatives planned and on-going in the NICU. Contractor and Erlanger agree that the mutual goal will be to continuously improve care, implementing best demonstrated practices and optimizing costs.

1.5 Participating Provider Arrangements.

1.5.1 Participation with Payors. Contractor and each of its Specialists shall use best efforts to maintain a participating provider arrangement with each governmental and commercial payor with which Erlanger maintains a participating provider arrangement, including without limitation (i) the S Network with BlueCross BlueShield of Tennessee; (ii) any payor with which Erlanger has a special product agreement; and (iii) any payor who insures one percent (1%) or more of Erlanger's inpatient population. Notwithstanding the foregoing, Contractor and each of its Specialists shall not be required to use best efforts to maintain a participating payor agreement with any payor who insures less than one percent (1%) of Erlanger's inpatient population unless otherwise specifically requested in good faith by Erlanger.

1.5.2 Failure to Maintain Participating Provider Arrangement(s). In the event Contractor either knows or has reason to know of a pending termination of a participating provider arrangement with a payor or is unable to reach agreement with a payor with which

Contractor is negotiating a participating provider arrangement, Contractor shall notify Erlanger and subsequently meet with Erlanger to discuss the reasons for such termination or impasse as well as to discuss possible resolutions. Contractor agrees to negotiate its participating provider arrangements in good faith.

1.6 Conflict Resolution. Contractor and Erlanger agree that appropriate, professional, and effective communication patterns are essential to optimal patient care. Both parties commit to work diligently and in good faith to create and maintain working relationships within their respective groups and with each other that employ sound communication and conflict resolution principles.

1.7 Oversight Committee. Contractor shall report to an oversight committee organized by and consisting of members chosen by Erlanger after collaboration in good faith with Contractor. The oversight committee shall meet every six (6) months unless otherwise determined by Erlanger. The oversight committee shall oversee the quality of patient care, patient safety and patient outcomes in the NICU.

1.8 UTCOM Arrangement. Contractor knows and understands that Erlanger is a teaching hospital committed to the mission of educating healthcare professionals and that Erlanger has formally contracted with University of Tennessee College of Medicine Chattanooga ("UTCOM") as its teaching site. Contractor and its Specialists shall support the pediatric residency programs of UTCOM at Erlanger and provide support for the academic responsibilities associated therewith consistent with the Specialists' obligations as members of the faculty of UTCOM. Contractor shall ensure that the Specialists execute faculty agreements with UTCOM as necessary to provide teaching services to UTCOM residents in the NICU, and Contractor agrees to work with UTCOM to the extent necessary for the Specialists to enter into such agreements. If such agreements are not reached with UTCOM, the failure to do so shall be considered a material breach of this Agreement. Contractor and the Specialists shall have sixty (60) days from the date that Erlanger provides Contractor with written notice of the Specialists' failure to execute faculty agreements with UTCOM to cure such material breach.

1.9 Medical Records. Contractor shall provide or cause to be provided to Erlanger written records and reports of all examinations, treatments and procedures performed pursuant to this Agreement ("Medical Records"). Erlanger agrees that Contractor will utilize Contractor's electronic medical records system and all applicable components to prepare and complete Medical Records unless Contractor determines in its sole discretion to utilize another method to prepare Medical Records. For each Medical Record prepared and completed using Contractor's electronic medical record system, Contractor shall prepare either an electronic copy or hard copy thereof and, in the case of an electronic copy, transmit such electronic copy to Erlanger in an agreed upon manner and, in the case of a hard copy, place such hard copy into the patient's medical file. In the event Contractor's electronic medical records system experiences an outage, Contractor shall utilize the appropriate Erlanger forms to dictate or prepare and complete a written medical record. Erlanger at all times shall be the official custodian of any medical record related to the services provided hereunder. Contractor agrees that all records and reports required by this Section shall be the exclusive personal property of Erlanger. However, during the term of this Agreement and thereafter, Erlanger shall provide Contractor with access to such

records and reports subject to the confidentiality provisions contained herein within five (5) days of receiving a request from Contractor.

1.10 Non-Exclusive Primary Provider; Exceptions. As Contractor is the non-exclusive primary provider of Neonatology Services hereunder, Erlanger shall not directly or indirectly employ, contract with, hire, permit, credential or otherwise engage any provider other than Contractor to provide Neonatology Services except as set forth below.

1.10.1 Erlanger may from time to time request that certain UTCOM faculty members board certified in Neonatology who are not Specialists (as defined in Section 2.1) (each, a "Faculty Member") be permitted to have access to the NICU as an extension of their academic functions on behalf of UTCOM. If Erlanger or Contractor at any time believes, in its reasonable judgment, that a Faculty Member is adversely affecting either the Neonatology Services provided by Contractor or the operations of the NICU, then the parties agree to meet immediately to discuss and attempt to resolve any such issues in a mutually satisfactory manner, and if applicable, shall make appropriate recommendations to the Medical Executive Committee or other appropriate committee(s) of Erlanger.

1.10.2 In the event that the Contractor performs this Agreement in a manner that adversely affects, or has the potential to adversely affect, patient care and Erlanger provides notice thereof to Contractor pursuant to Section 7.2 and Contractor fails to cure such breach within thirty (30) days of such notice, then Erlanger shall have the right to contract with non-Contractor physicians and/or other personnel as necessary to perform the neonatology services that have been affected by Contractor's breach. Erlanger shall determine whether the best interests of the program are better served by continuing this Agreement or by terminating this Agreement and providing for different coverage arrangements.

2. Specialists.

2.1 Retention of Specialists. The Neonatology Services to be rendered pursuant to this Agreement shall be performed by physicians and/or nurse practitioners acceptable to Erlanger who are employees of or otherwise engaged by the Contractor (all such physicians and nurse practitioners hereinafter referred to individually as a "Specialist" and collectively as the "Specialists"; provided, however, that the foregoing terms shall not be interpreted to include any non-Contractor Faculty Member). Contractor shall employ, contract with and/or retain a sufficient number of Specialists (as mutually determined by Erlanger and Contractor) acceptable to Erlanger to satisfy the duties imposed hereunder.

2.2 Qualifications of Specialists. Contractor has reviewed the credentials of the Specialists and represent and warrant that all Specialists providing services in accordance with this Agreement shall:

2.2.1 If a physician, maintain an unrestricted license to practice medicine in the State of Tennessee. If nurse practitioner, maintain an unrestricted license as a neonatal nurse practitioner in the State of Tennessee.

2.2.2 If a physician, meet the educational, training and licensure requirements to sit for the neonatal-perinatal certifying examination or be board certified in the specialty of neonatal-perinatal medicine. If a nurse practitioner, be certified by the National Certification Corporation (N.C.C.) as a neonatal nurse practitioner. Erlanger acknowledges that Contractor may employ physicians who are board certified in general pediatrics, and Erlanger further agrees that each such physician shall be allowed to be a Specialist providing Neonatology Services hereunder so long as such physician is supervised by a physician board certified in the specialty of neonatal-perinatal medicine and approved by the Senior Vice President of Children's Services at Erlanger, or his/her designee (in the event Erlanger has notified Contractor in writing of such designation).

2.2.3 If a physician, qualify for and maintain medical staff membership and clinical privileges at Erlanger. If a nurse practitioner, be credentialed in accordance with Erlanger's Medical Staff requirements.

2.2.4 Agree to comply with, and be governed by, all the terms and conditions of this Agreement.

2.2.5 Meet all other professional qualifications and standards set forth herein and in the bylaws of Erlanger's Medical Staff.

2.2.6 If a physician, maintain appointment to the UTCOM faculty if requested by Erlanger.

2.2.7 Comply with Erlanger's Code of Conduct and Ethics, Stark and Anti-Kickback policy and Compliance Program (collectively, the "Compliance Program"), as such Compliance Program relates to the Neonatology Services and may include training as reasonably requested by Erlanger.

3. Contractor Outside Activities. Erlanger acknowledges that the Contractor is currently, and will continue to be, involved in performing medical duties in the nature of those provided pursuant to this Agreement for entities other than Erlanger. The Contractor shall not be prohibited from engaging in such activities outside of Erlanger, so long as the Contractor continues to satisfy the provisions of this Agreement. Contractor represents and warrants that it is not subject to any contractually or judicially imposed restriction that would prevent or in any way limit its performance of the terms of the Agreement. Notwithstanding the foregoing, Contractor shall strongly support the growth of the NICU at Erlanger's facilities.

4. Financial Arrangement.

4.1 Contractor Billing and Collection. The Contractor shall separately bill and collect for the Neonatology Services furnished by Specialists to patients of Erlanger. Erlanger shall take all steps reasonably requested by the Contractor to provide information, including appropriate medical records (if permitted by law) to assist in the billing and collection of fees for those Neonatology Services.

4.2 Erlanger Billing and Collection. Erlanger shall be entitled to charge patients separately for the non-professional services rendered by the Contractor and to receive direct payment therefore without any charges made against the same by the Contractor. The Contractor shall take all steps reasonably requested by Erlanger to provide information to assist in the billing and collection of fees for those services.

5. Obligations of Erlanger

5.1 Compensation. During the term of this Agreement Erlanger shall pay the Contractor Five Hundred Seventy Three Thousand Dollars ($573,000.00) per annum payable in equal installments of Forty Seven Thousand Seven Hundred Fifty Dollars ($47,750.00) per month for being able to provide the Neonatology Services set forth herein. Erlanger shall make payment on or before the 5th day of each month following a month in which services were rendered. The parties stipulate that the amount paid under this Agreement represents fair market value for the Neonatology Services. No payment under this Agreement shall be used for any purpose other than Contractor's compensation for the Neonatology Services provided hereunder and shall not otherwise inure to the benefit of any other person or entity.

5.2 Facilities, Equipment, Records. Erlanger shall make available for use by any Specialist all facilities, equipment, furniture, files, office equipment, instruments, and any and all other items as may be needed for the proper and efficient operation and conduct of the NICU and to facilitate the provision of Neonatology Services. All such facilities, equipment, furniture, files, office equipment, instruments and any other items provided shall be and shall remain the property of Erlanger. Contractor shall be permitted to install computer terminals and appropriate connections so that data can be electronically transferred to its corporation in support of its business and clinical obligations solely for the purpose of providing the Neonatology Services hereunder.

5.3 Staffing. Erlanger shall provide sufficient clerical and technical staff to provide for the proper operation of its departments providing care to newborns. All technical staff shall be properly licensed or certified, in accordance with any applicable criteria.

5.4 Medical Director of Neonatology Services. Erlanger and Contractor agree that a physician shall be appointed to serve as the medical director of Neonatology Services (the "Medical Director") during the term of this Agreement. Dr. Woods Blake shall be the initial Medical Director. The Medical Director shall perform those administrative services set forth on the attached Schedule 5.4. If Erlanger determines in its sole discretion that it is necessary to replace the Medical Director, Erlanger shall discuss such determination with Contractor and if Erlanger and Contractor agree that the Medical Director should be replaced, Contractor shall appoint a successor Medical Director with the approval of Erlanger, which approval shall not unreasonably be withheld.

6. Term. Subject to Section 7, this Agreement shall commence on the Effective Date and continue through January 31, 2014. Thereafter, this Agreement shall automatically renew for successive, additional one (1) year terms unless either party provides at least one hundred twenty (120) days prior written notice of nonrenewal to the other party.

7. Termination.

7.1 Immediate Termination. If any of the following events occur to a Specialist, Contractor shall prohibit such Specialist from performing Neonatology Services:

7.1.1 The Specialist's medical staff membership or clinical privileges in neonatology at Facility are suspended or revoked in accordance with the by-laws of the medical staff of Facility;

7.1.2 The Specialist's license to practice medicine in the State of Tennessee is suspended or revoked;

7.1.3 The Specialist is convicted of a felony or a crime of moral turpitude or the Specialist is excluded from participation in any federal or state health program;

7.1.4 The Specialist becomes disabled or impaired to the extent he or she is unable to perform the duties required by this Agreement;

7.1.5 The Specialist commits any grossly negligent act or omission which jeopardizes the health or safety of a patient.

If, after gaining knowledge of such event, Contractor fails to prohibit the relevant Specialist from performing Neonatology Services, then Erlanger may terminate this Agreement in accordance with Section 7.2 hereafter. If a Specialist is required to be removed or otherwise fails to be available to provide services to Erlanger, Contractor shall immediately notify Erlanger and Contractor shall supply a replacement immediately or otherwise insure that continuous coverage is maintained satisfactory to Erlanger.

7.2 Material Breach. Either party may terminate this Agreement upon a material breach of this Agreement by the other party if the non-breaching party provides sixty (60) days advance written notice of the alleged breach to the other party, and if the other party fails to reasonably cure such breach within such sixty (60) day time frame. The parties acknowledge and agree that a breach by a Specialist of the terms of this Agreement shall be deemed a breach by Contractor. In the event a breach occurs which adversely affects patient care, such breach shall be cured within thirty (30) days.

7.3 Legislative or Administrative Changes. In the event that there is a change in the Medicare or Medicaid laws, regulations, or general instructions (or interpretations thereof), the adoption of new legislation, or the adoption of regulations, any of which materially and adversely affect the relationship of the parties to one another hereunder, or otherwise make the performance of any material term or condition of this Agreement illegal or impossible, then the parties shall, upon written notice of one party to the other of such event, negotiate in good faith using their best efforts to modify this Agreement in order to comply with any such change. In the event the parties are unable thereafter to agree upon a reasonable modification to this

Agreement, either party may terminate this Agreement upon thirty (30) days prior written notice to the other or as otherwise required by law.

7.4 Financial Arrangements Following Termination. Should either party terminate this Agreement before the expiration of the first year of its term, Erlanger and Contractor shall not enter into any financial arrangement for the Neonatology Services covered by this Agreement until the expiration of such first year of the term of this Agreement unless such arrangement is in compliance with the terms of 42 U.S.C. § 1395nn et seq. and regulations adopted pursuant thereto, and 42 U.S.C. § 1320a-7b(b) and regulations adopted pursuant thereto.

8. Insurance

8.1 Type, Amount. The Contractor shall maintain, during the term of this Agreement and at its sole expense, group professional liability insurance covering the Specialists for the Neonatology Services rendered by such Specialists pursuant to this Agreement in the minimum amount of $1,000,000 per claim and $3,000,000 per year subject to applicable aggregates, or such other amounts as may be agreed to by the parties in writing. The Contractor shall also obtain and maintain general liability insurance for the Neonatology Services rendered by the Specialists pursuant to this Agreement in the minimum amounts of $1,000,000 per claim and $2,000,000 in the annual aggregate. At the request of Erlanger, the Contractor shall provide Erlanger with certificates of such insurance coverage. Contractor shall request that its insurance carrier notify Erlanger at least thirty (30) days following any cancellation or non-renewal of said coverage or material change that affects the coverage related to the Services provided under this Agreement.

8.2 Continuation of Insurance. Upon termination of this Agreement for any reason, Contractor shall either continue professional liability insurance or obtain a policy of tail insurance for professional liability claims made after the termination of this Agreement for services rendered during the Term of this Agreement. Such insurance shall be maintained in at least the minimum coverage amounts specified above.

9. Books and Records.

9.1 Medical Records. The Contractor shall, in accordance with Erlanger policies, promptly cause to be prepared and filed with Erlanger's medical records department written reports of all examinations, procedures or other Neonatology Services performed pursuant to this Agreement. The ownership and right of control of all reports, records, and supporting documents prepared in connection with the operation of the NICU shall vest exclusively in Erlanger; provided, however, that the Contractor shall have the right of access to such reports, records, and supporting documentation as may be reasonably necessary, or as provided by law or Erlanger policies.

9.2 Access to Books, Documents and Records. If required by the applicable provisions of the Social Security Act related to reasonable cost provisions of hospitals, until the expiration of four (4) years after the termination of this Agreement, the Contractor shall make available, upon written request from the Secretary of the United States Department of Health and Human Services, the Comptroller General of the United States, or their duly authorized representatives, a

copy of this Agreement and such books, documents and records as are necessary to certify the nature and extent of the cost of the services provided by the Contractor under this Agreement. The Contractor further agrees that if it carries out any of its duties under this Agreement through a subcontract with a related organization with a value or cost of $10,000 or more over a twelve (12) month period, then such contract shall contain a clause similar in scope to this section.

9.3 HIPAA Compliance.

9.3.1 The Contractor and Erlanger each agree to comply with the applicable provisions of the Administrative Simplification section of the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. § 1320d through d-8 ("HIPAA"), and the requirements of any regulations promulgated thereunder, including, without limitation, the federal privacy regulations as contained in 45 CFR Parts 160 and 164 (the "Federal Privacy Regulations") and the federal security standards as contained in 45 CFR Part 164 (the "Federal Security Regulations"). The Contractor and Erlanger each agree not to use or further disclose any protected health information, as defined in 42 U.S.C. § 1320d and 45 CFR § 164.501(collectively, the "Protected Health Information"), concerning a patient other than as permitted or required by this Agreement or otherwise authorized under HIPAA

9.3.1 As permitted under HIPAA, the parties hereby agree, that by virtue of this Agreement, they are an "organized health care arrangement" for purposes of meeting the Federal Privacy Regulations and the authorized use and disclosure of Protected Health Information thereunder. Further, Erlanger will include the Contractor in its required notice of privacy practices for the purpose of allowing both parties to meet the notice requirements under the Federal Privacy Regulations and the Contractor agrees to follow the privacy practices adopted by Erlanger as detailed in its notice of privacy practices.

10. Status of Parties. It is expressly acknowledged by the parties hereto that the Contractor is an independent contractor, and nothing in this Agreement is intended nor shall be construed to create an employer/employee relationship, or to allow Erlanger to exercise control or direction over the manner or method by which the Contractor or any Specialist performs the Neonatology Services which are the subject matter of this Agreement. The Contractor understands and agrees that Erlanger will not withhold on behalf of the Contractor or any Specialist any sums for income tax, unemployment insurance, social security, or any other withholding pursuant to any law or requirement of any government body, or make available to the Contractor or any Specialist, any of the benefits afforded to employees of Erlanger, and all such payments, withholdings and benefits, if any, are the sole responsibility of the Contractor or the Specialists. In the event the United States Internal Revenue Service (the "IRS") should question or challenge the independent contractor status of the Contractor or any Specialist, the parties hereto mutually agree that both the Contractor and Erlanger shall have the right to participate in any discussion or negotiation occurring with the IRS, irrespective of who initiates such discussion or negotiations.

11. Intentionally Omitted.

12. Other Service Arrangements. During the term of this Agreement, Contractor shall notify the Senior Vice President of Children's Services at Erlanger, or his/her designee (in the event Erlanger has notified Contractor in writing of such designation) (i) prior to Contractor or any of Contactor's employees, contractors or representatives initiating contact with a New Location for the purposes of having Contractor provide pediatric subspecialty services or maternal fetal medicine services at the New Location or (ii) if a New Location initiates contact with Contractor or any of Contractor's employees, contractors, or representatives for the purposes of having Contractor provide pediatric subspecialty services or maternal fetal medicine services at the New Location, following Contractor's receipt of such contact. While Contractor agrees to provide the notice set forth above, this provision shall not restrict Contractor in any way from providing services to, contacting or otherwise communicating with any New Location. For the purposes of this Section 12, a "New Location" shall mean any hospital, facility or other provider of health care located within seventy-five (75) nautical miles of T.C. Thompson to which Contractor was not providing Neonatology Services as of the Effective Date.

13. Dispute Resolution. If any controversy or claim arising out of or relating to this Agreement shall arise during the term of this Agreement (a "Pre-Termination Dispute"), then the parties agree to engage first in negotiations in an attempt to resolve in good faith such Pre-Termination Dispute. If a Pre-Termination Dispute is not resolved pursuant to such negotiations or if any controversy or claim arising out of or relating to this Agreement shall arise after the term of this Agreement (a "Post-Termination Dispute"), then such Pre-Termination Dispute or Post-Termination Dispute, as applicable, shall be submitted to mediation prior to either party resorting to litigation. The mediation will be held in Chattanooga, Tennessee and shall be before a mediator chosen by agreement of the parties. If the parties are unable to agree to a mediator within ten (10) days of one party notifying the other that mediation is requested, the mediation shall be administered by the American Arbitration Association under its Mediation Procedures. Mediation shall be held before either party may resort to litigation. Notwithstanding the foregoing, this section shall not limit or restrict the parties with respect to matters for which an injunction, restraining order, writ of mandamus, specific performance or other equitable relief may be sought by a party hereunder.

14. Miscellaneous.

14.1 Notices. Any notice required or permitted to be given hereunder to either party shall be deemed given if sent by hand delivery, registered or certified mail, return receipt requested, or by overnight mail delivery for which evidence of delivery is obtained by the sender, to such party at:

Contractor: Pediatrix Medical Group of Tennessee, P.C.
1300 Sawgrass Corporate Parkway, Suite 200
Sunrise, Florida 33323
Attn: Regional President

With a copy to:

Pediatrix Medical Group of Tennessee, P.C.

1301 Concord Terrace
Sunrise, Florida 33323
Attn: General Counsel

Erlanger: Chattanooga-Hamilton County Erlanger Authority
Attn: Senior Vice President of Children's Services
Erlanger Health System
975 East Third Street
Chattanooga, TN 37403

with a copy to:
Chattanooga-Hamilton County Erlanger Authority
975 E. Third Street
Chattanooga, Tennessee 37403
Attn: Legal Department

14.2 Limitation of Assignment. This Agreement shall not be assigned by either party without the prior express written consent of the other party. Notwithstanding the foregoing, this Agreement may be assigned to (i) any corporation or other entity of any kind succeeding to the business of either party in connection with the merger, consolidation, sale or transfer of the stock or all or substantially all of the assets and business of such party to such successor or with a corporate reorganization involving such party; or (ii) to any subsidiary, parent corporation or other affiliate of either party, so long as the assignee (whether for reasons set forth in subsections (i) or (ii)) has not been excluded or barred from participation in any state or federal health care program, has not been convicted of a federal offense related to health care, executes an Assignment and Assumption Agreement whereby the assignee expressly agrees to assume all of the duties, liabilities, representations and warranties of the assigning party under this Agreement.

14.3 Binding on Successors-in-Interest. The provisions of, and obligations arising under, this Agreement shall extend to, be binding upon, and inure to the benefit of the successors and permitted assigns of each party.

14.4 Severability; Changes in Law. If any part of this Agreement is determined to be invalid, illegal, inoperative, or contrary to law or professional ethics, the part shall be reformed, if possible, to the extent required to conform to law and ethics; the remaining parts of this Agreement shall be fully effective and operative to the extent reasonably possible. If any restriction contained in this Agreement is held by any court to be unenforceable or unreasonable for any reason, then such restriction shall be modified to the extent required to render it enforceable and the remaining restrictions shall be enforced independently of each other.

14.5 Compliance With Law. The parties shall comply with all applicable law, including but not limited to the Ethics in Patient Referrals Act and the Medicare and Medicaid Anti-Fraud and Abuse Law. It is the intent of the parties that this Agreement shall satisfy relevant exceptions set for in the Ethics in Patient Referrals Act, 42 U.S.C. §1395nn and, to the extent possible, safe harbor provisions published at 42 C.F.R. §1001.952 (under the Medicare and Medicaid Anti-Fraud and Abuse Law, 42 U.S.C. §1320a-7b). If a party reasonably

determines that this Agreement does not satisfy relevant exceptions or safe harbors or comply with applicable law, or would otherwise bar referrals from Contractor, any physician members or agents of Contractor and/or Specialists to Erlanger, that party may suspend the operation of this Agreement and immediately upon the provision of written notice to the other party specifying the ground(s) for suspension of the Agreement. Immediately thereafter, the parties shall meet and confer in good faith and attempt to modify the Agreement to comply with applicable law. If the parties cannot agree that a modification is necessary to comply with applicable law or satisfy relevant safe harbors and exceptions, or upon the terms of such modification, within sixty (60) days of the date of the tendered written notice of suspension, this Agreement shall terminate automatically. Contractor hereby represents and warrants, in good faith, that Specialists, physician employees and/or contractors of Contractor, and/or their immediate family members, receive only aggregate compensation from Contractor which is consistent with fair market value for services furnished and does not take into account or otherwise reflect referrals or other business generated by such Specialists; physician employees and/or contractors for the benefit of Erlanger and that all such relationships otherwise satisfy the exception provided for "indirect" compensation relationships set for in 42 C.F.R. § 411.357(p).

14.6 Time of the Essence. Time shall be of the essence with respect to each and every term, covenant and condition of this Agreement.

14.7 Entire Agreement/Amendment. This Agreement supersedes all previous contracts (including that certain Neonatology Agreement dated March 1, 2005) and constitutes the entire agreement between the parties for the services provided under this Agreement. Oral statements or prior written materials not specifically incorporated in this Agreement shall not be of any force and effect. In entering into and executing this Agreement, the parties rely solely upon the representations and agreements contained in the Agreement and no others. No changes in, or additions to, this Agreement shall be recognized unless and until made in writing and signed by an authorized officer or agent of the Contractor and Erlanger.

14.8 Governing Law. This Agreement has been executed and delivered and shall be construed and enforced in accordance with the laws of the State of Tennessee. Any action by any party, whether at law or in equity, shall be exclusively commenced and maintained and venue shall properly be in Chattanooga, Tennessee.

14.9 Waiver of Breach. No provision of this Agreement shall be deemed waived unless evidenced by a written document signed by an authorized officer or agent of the parties. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as, or be construed to be, a waiver of any subsequent breach of the same or other provision of this Agreement.

14.10 Section and Other Headings. The section and other headings contained in this Agreement are for reference purposes only and shall not affect in anyway the meaning or interpretation of this Agreement.

14.11 Gender and Number. When the context of this Agreement requires, the gender of all words shall include the masculine, feminine, and neuter, and the number of all words shall include the singular and plural.

14.12 Execution. This Agreement and any amendments may be executed in multiple originals; each counterpart shall be deemed an original, but all counterparts together shall constitute one and the same instrument.

14.13 Additional Assurances. The provisions of this Agreement are self-operative and do not require further agreement by the parties; provided, however, at the request of either party the other shall execute, except as otherwise provided in this Agreement, any additional instruments and take any additional acts as may be reasonably necessary to effectuate this Agreement.

14.14 Authority. Each signatory to this Agreement represents and warrants that he possesses all necessary capacity and authority to act for, sign, and bind the respective entity on whose behalf he is signing.

14.15 Good Standing. Contractor represents and warrants that, to the best of its knowledge, it has not been, and none of the shareholders, members, employees, agents or contractors has been, excluded or barred from participation in Medicare or a federal health care program and/or convicted of a criminal offense relating to healthcare.

14.16 Responsible for Own Acts. The parties agree to be solely responsible for any and all liabilities, damages, costs, expenses (including reasonable attorneys' fees) (collectively, the "Damages") arising from or relating to the negligent acts or omissions of their respective officers, employees, contractors or agents in the performance of their duties and obligations hereunder. Nothing contained herein shall be construed to require either party to indemnify or otherwise assume liability for any Damages or the acts or omissions of the other party, its affiliated entities, shareholders, officers, employees, contractors or agents. In no event shall this provision be construed to expand Erlanger's legal obligations or limitations of liability as provided in the Tennessee Governmental Tort Liability Act codified at Tennessee Code Annotated Sections 29-20-101 *et seq.*, as applicable to the Neonatology Services

14.17 Other Arrangements. In accordance with the terms of 42 CFR § 411.357(d)(1)(ii), Erlanger shall maintain a list of all separate arrangements entered into between Erlanger and Contractor (the "Master List") in such a manner that preserves the historical record of any and all agreements between the parties. The Master List maintained by Erlanger shall be updated centrally and shall be available for review by the Secretary of the Department of Health and Human Services upon request.

14.18 Entire Agreement. Other than those agreements set forth in the Master List, this Agreement sets forth the entire understanding and agreement of the parties with respect to the subject matter hereof and supersedes any and all prior agreements, negotiations, arrangements, writings, or other documents heretofore entered into by the parties.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized representatives.

PEDIATRIX MEDICAL GROUP OF TENNESSEE, P.C.

By: _____
Alan Oliver, Authorized Signatory

Date: 12-2-11

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY D/B/A/ ERLANGER HEALTH SYSTEM

By: _____
Alan B. Kohrt, M.D., FAAP, Senior Vice President of Children's Services

Date: 11/9/11

Supplemental #2
-Original-

Chattanooga-Hamilton Co Hospital Authority d/b/a Erlanger East Hospital

CN1601-002

SUPPLEMENTAL INFORMATION *(No. 2)*

Chattanooga-Hamilton County Hospital Authority

D / B / A

Erlanger East Hospital

Application To Modernize The Certificate Of Need

Originally Issued In 2004 (No. CN0405-047AE)

By Initiating A Level III Neonatal Intensive Care Unit,

Reclassifying Medical / Surgical Beds To Neonatal,

And Transferring Medical / Surgical Beds

Application Number CN1601-002

January 28, 2016

ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

Supplemental Responses To Questions Of The Tennessee Health Services & Development Agency

1.) **Section A, Applicant Profile, Item 9 (Bed Complement Table) and Section B, Project description, Item II.B (Changes in Bed Complement).**

The clarification of the bed complement table on page 4 of the 1/26/16 supplemental response identifying Erlanger East Hospital's 6 existing NICU Level II beds approved in CN0407-067A is noted. However, some changes may be warranted as follows:

"CON Approved Beds" Column: Please revise to show a total of 70 CON approved beds remaining in lieu of the 80 beds noted. It appears the following may be helpful

- **Delete +42 surgical and +22 medical in the column and replace with the 46 medical and 24 surgical beds identified in footnote #3.**

- **Delete +16 NICU beds in the column (existing 6 Level II beds are already shown as implemented in the "CON beds implemented column". Additionally, the 10 beds proposed in this application, CN1601-002, should be shown only in the "Beds Proposed" column.**

"Beds Proposed" Column: Please revise to show only the 10 Level III NICU beds proposed in the application, CN1601-002.

Please make the necessary corrections and resubmit the bed complement table for Erlanger East Hospital.

Response

Certain changes to the table have been revised, as requested. There are a total of seventy (70) beds which remain to be implemented of the seventy-nine (79) additional beds at *Erlanger East Hospital* (no. CN0405-047AE). Of the remaining beds which remain to be implemented, forty-four (44) beds will be medical, twenty-two (22) beds will be surgical and six (6) beds will be Level II neonatal.

		Erlanger East Licensed Beds July, 2004	*(*) CON Beds Implemented*	*(*) CON Beds Approved & Remaining*	*Current Staffed Beds*	*Beds Proposed*	*TOTAL Beds at Completion*
A.	Medical	4		42	8		50
B.	Surgical	8		22	4		26
C.	Long-Term Care Hospital						
D.	Obstetrical	16	+9		25		25
E.	ICU / CCU						
F.	Neonatal		+6	6	6	10	22
G.	Pediatric						
H.	Adult Psychiatric						
I.	Geriatric Psychiatric						
J.	Child / Adolescent Psychiatric						
K.	Rehabilitation						
L.	Nursing Facility (Non – Medicaid Certified)						
M.	Nursing Facility Level 1 (Medicaid only)						
N.	Nursing Facility Level 2 (Medicare only)						
O.	Nursing Facility Level 2 (dually certified Medicaid / Medicare)						
P.	ICF / MR						
Q.	Adult Chemical Dependency						
R.	Child and Adolescent Chemical Dependency						
S.	Swing Beds						
T.	Mental Health Residential Treatment						
U.	Residential Hospice						
	TOTAL	28	+15	70	43	10	123

(*) CON Beds approved but not yet in service.

Notes

(1) *Erlanger East Hospital* received a CON to transfer six (6) beds from *Erlanger Medical Center* (no. CN0407-067A) for it's Level II *Special Care Nursery* and this has been implemented.

(2) *Erlanger East Hospital* holds a CON for the transfer of up to 79 beds from *Erlanger Medical Center* (no. CN0405-047AE). Nine (9) beds have already been implemented in this process.

(3) *Erlanger East Hospital* has 70 beds remaining (42 medical, 22 surgical & 6 Level II neonatal) to implement under CON No. CN0407-047AE.

(4) The total of neonatal beds at Erlanger East Hospital upon completion of all projects will be twenty-two (22), twelve (12) Level II beds and ten (10) Level III beds.

2.) Section B Project Description, Item I (Executive Summary).

The clarification of the items requested for the Executive Summary of the project is noted. Please provide additional information for the following:

Service Area - For the Southeast Region, the response indicates that 67% of EMC's NICU utilization originated from the 10-County region in CY 2015. In light of the list provided in the supplemental response showing all 18 TN counties and the TN Perinatal Regions they belong to, what was the utilization of EMC's NICU service from all of the 18 TN counties in CY 2015?

Need - Please expand the remarks to show the applicant's estimate of the number of beds needed in CY 2020 for the 18 TN County portion of the service area.

Existing Resources - Please show the existing number of level II and above NICU beds for the 18 TN county portion of the service area.

Response

As requested, revisions have been made to the appropriate items.

Service Area

The NICU for *Children's Hospital @ Erlanger* is well situated for the *Southeast Tennessee Perinatal Regional* service area as evidenced by the patient origin.

In CY 2015, 67% of NICU patients were from the ten (10) county service area which comprises the *Southeast Tennessee Perinatal Regional* service area. In CY 2014 64% of NICU patients came from this geography.

In CY 2015, 74% of NICU patients were from the eighteen (18) county NICU *Tennessee* service area. In CY 2014, 71% of NICU patients came from this geography.

Need

Transfers from the Level II unit at *Erlanger East Hospital* contributing to the need for this project is minimal. As evidence of this, the number of transfers to the NICU at *Children's Hospital @ Erlanger* in CY 2015 was 26.

Per the bed need calculation shown in the table on page 12 of the first supplement to this CON application, there are a total of 90.4 neonatal beds needed in the Tennessee service area, based on Tennessee birth rates in that geography for CY 2014. However, when this is adjusted for occupancy the total number of neonatal beds needed is 113. It is customary to adjust the gross bed need calculation by the occupancy assumption to allow for growth of the service area need; otherwise, the occupancy would be 100% of need. The 80% occupancy assumption is derived from the most recent assumption of NICU criterion currently proposed for CON's by the *Division of Health Planning*. Also, it is important to have some degree of flexibility in highly specialized services for unanticipated demand and/or clinical need.

As demonstrated by the payor mix data in this supplemental information, 67% of our NICU utilization is *TennCare* and Medicaid, evidencing the need for a "system of care" among those which are most vulnerable, the neonatal patients of low income families. Thus, it is apparent to *Erlanger* management that we need to provide such a "system of care" within the neonatal healthcare system in southeast Tennessee.

Need is also a function of enabling access for less high risk mothers and infants and providing an opportunity to deliver at *Erlanger East Hospital*. This will decrease the utilization of the NICU for *Children's Hospital @ Erlanger*, and provide the same high level of care with the same neonatologist and Neonatal Nurse Practitioner's at both NICU's.

Existing Resources

In addition to the NICU and neonatal services that are offered by *Children's Hospital @ Erlanger*, as a *Tennessee Regional Perinatal Center* the program provides direct medical care and consultation services to women with complex medical conditions or with high risk pregnancy. We also provide ongoing education to other community hospitals and providers in the *Tennessee Southeast Perinatal Region*. There are a total of one hundred six (106) neonatal and NICU beds within the geography of the Tennessee service area for this project.

3.) Section C. Need (Project Specific Criteria: NICU-Items 1 and 2.

The table provided in the 1st supplemental response is noted.

The applicant uses an occupancy adjustment factor of 80% to arrive at a CY 2020 bed need estimate of 113 NICU beds in the 18 TN county portion of the service area (90.4 beds/.80 = 113 beds). Please describe the key reasons an occupancy adjustment should be used to estimate NICU bed need in the service area. In your response, please explain how the 80% occupancy factor for CY 2020 was determined.

Please clarify why a CY 2020 bed need of 116.4 beds is identified in footnote#3 in lieu of the 113 beds shown in the table.

Please add a column to the table provided in the 1st supplemental response that identifies the county of location of the 106 existing Level II and above NICU service area provider beds identified in the table on page 51 of the application.

Projected Births with Fertility Rates and NICU Bed Need in Applicant's TN Service Area,
(total births-all ages per 1,000 females aged 15-44 using 2014 TN resident data)

COUNTY	EMC Service Area Type	Births	Fertility Rate	Age 15-44 Population 2020	Births 2020	Bed Need 2020	Existing NICU Beds
Bledsoe*	SSA						
Bradley*	SSA						
Grundy*	SSA						
Hamilton*	PSA						
McMinn*	SSA						
Marion*	SSA						
Meigs*	SSA						
Polk*	SSA						
Rhea*	SSA						
Sequatchie*	SSA						
Coffee	TSA						
Subtotal-Southeast Perinatal Region	10 Counties						
Cumberland	TSA						
Franklin	TSA						
Loudon	TSA						
Monroe	TSA						

Roane	TSA						
Van Buren	TSA						
Warren	TSA						
Total-EMC Service Area	**18 Counties**						

Response

In the bed need calculation shown in the table on page 12 of the first supplement to this CON application, there are a total of 90.4 neonatal beds needed in the Tennessee service area, based on Tennessee birth rates in that geography for CY 2014. However, when this is adjusted for occupancy the total number of neonatal beds needed is 113. It is customary to adjust the gross bed need calculation by the occupancy assumption to allow for growth of the service area need; otherwise, the occupancy would be 100% of need. The 80% occupancy assumption is derived from the most recent assumption of NICU criterion currently proposed for CON's by the *Division of Health Planning*. Also, it is important to have some degree of flexibility in highly specialized services for unanticipated demand and/or clinical need.

As requested, the revision showing the number of neonatal and NICU beds in the service area has been added to the table.

Projected Births With Fertility Rates & NICU Bed Need In Applicant's Tennessee Service Area

(Total Births - All Ages Per 1,000 Females Aged 15-44 Using Tennessee Resident Data)

County	EMC Service Area	Females Age 15-44 CY 2014	Births CY 2014	Fertility Rate	Females Age 15-44 CY 2020	Projected Births CY 2020	Bed Need CY 2020	Existing NICU Beds
Bledsoe (*)	SSA	1,941	119	61.3	1,940	119	1.0	
Bradley (*)	SSA	20,475	1,206	58.9	21,288	1,254	10.0	3
Grundy (*)	SSA	2,316	151	65.2	2,051	134	1.1	
Hamilton (*)	PSA	69,764	4,144	59.4	70,095	4,164	33.3	92
Marion (*)	SSA	5,000	324	64.8	4,543	294	2.4	
McMinn (*)	SSA	9,437	553	58.6	9,313	546	4.4	11
Meigs (*)	SSA	1,925	102	53.0	6,307	334	2.7	
Polk (*)	SSA	2,850	177	62.1	2,881	179	1.4	
Rhea (*)	SSA	5,944	384	64.6	6,192	400	3.2	
Sequatchie (*)	SSA	2,508	152	60.6	2,701	164	1.3	
Subtotal - Southeast Perinatal Region	**10 Counties**	122,160	7,312	61.3	127,311	7,588	60.8	106
Coffee	TSA	9,816	693	70.6	10,180	719	5.8	
Cumberland	TSA	8,405	548	65.2	8,661	565	4.5	
Franklin	TSA	7,600	399	52.5	7,609	399	3.2	
Loudon	TSA	7,932	510	64.3	8,121	522	4.2	
Monroe	TSA	7,627	527	69.1	7,815	540	4.3	
Roane	TSA	8,457	433	51.2	8,383	429	3.4	
Van Buren	TSA	893	61	68.3	818	56	0.4	
Warren	TSA	1,160	77	66.4	7,226	480	3.8	
Total - EMC Service Area - In Tennessee	**18 Counties**	174,050	10,560	62.2	186,124	11,298	90.4	106
					Occupancy Adjustment		80%	
				CY 2020 Bed Need With Occupancy Adjustment			113.0	

Notes

(1) The formula for estimated births in CY 2020 is … Females-2020 x Fertility Rate = Projected Births-2020.

(2) The formula for estimated bed need in CY 2020 is … (Projected Births-2020 / 1000) x 8 beds per thousand = Bed Need-2020.

(3) The bed need calculated by the table provided by the *Tennessee Health Services Agency* is unadjusted. Including an occupancy adjustment of 80%, the bed need of 113.0 is reflective of the proposed neonatal CON standards currently being developed.

4.) Section C, Need, Item 4.a (Demographics of Service Area).

The table provided in replacement page 48-R is noted. Based on the declared service area for the project shown in the application, it appears demographic information is missing for Cumberland, Loudon and Roane Counties. In addition, White County was not part of the service area identified in the application. Please revise the table and resubmit with your response. As a reference, TN service area counties

identified in the application are noted in the table below.

Patient Origin – Erlanger Medical Center NICU Service

COUNTY	EMC Service Area Type	Births by Female Residents 2014	Infant Utilization at EMC NICU Service Units* 2014
Bledsoe*	SSA		
Bradley*	SSA		
Grundy*	SSA		
Hamilton*	PSA		
McMinn*	SSA		
Marion*	SSA		
Meigs*	SSA		
Polk*	SSA		
Rhea*	SSA		
Sequatchie*	SSA		
Coffee	TSA		
Subtotal-Southeast Perinatal Region	**10 Counties**		
Cumberland	TSA		
Franklin	TSA		
Loudon	TSA		
Monroe	TSA		
Roane	TSA		
Van Buren	TSA		
Warren	TSA		
Total-EMC Service Area	**18 Counties**		

Response

As requested, the demographic table has been revised to show the appropriate counties in the Tennessee service area.

	Hamilton	Bradley	Marion	Grundy	Sequatchie	Bledsoe
Current Year (2016) - Age 65+	61,073	17,879	5,763	3,021	3,195	2,628
Projected Year (2020 - Age 65+	69,752	20,381	6,584	3,339	3,896	2,955
Age 65+ - % Change	14.2%	14.0%	14.2%	10.5%	21.9%	12.4%
Age 65+ - % Total	17.1%	16.9%	20.2%	22.4%	20.2%	19.8%
Total Pop. - 2016	356,156	105,549	28,585	13,470	15,835	13,273
Total Pop. - 2020	368,666	109,706	28,633	13,263	16,943	13,481
Total Pop. - % Change	3.5%	3.9%	0.2%	-1.5%	7.0%	1.6%
Median Age	39	38	42	41	41	42
Median Household Income	$46,702	$41,083	$41,268	$26,814	$36,434	$33,443
TennCare Enrollees	61,399	20,321	6,636	4,626	3,716	3,082
TennCare Enrollees As % Of Total Pop.	17.2%	19.3%	23.2%	34.3%	23.5%	23.2%
Persons Below Poverty Level	59,979	20,664	5,215	3,957	2,653	2,825
Persons Below Poverty Level As % Of Total Pop.	16.8%	19.6%	18.2%	29.4%	16.8%	21.3%

	Rhea	Meigs	McMinn	Polk	Franklin	Coffee
Current Year (2016) - Age 65+	6,589	2,677	11,089	3,680	8,752	10,225
Projected Year (2020 - Age 65+	7,571	3,151	12,650	4,134	9,972	11,573
Age 65+ - % Change	14.9%	17.7%	14.1%	12.3%	13.9%	13.2%
Age 65+ - % Total	19.4%	21.9%	20.4%	21.1%	20.8%	18.3%
Total Pop. - 2016	33,934	12,221	54,449	17,442	42,097	55,932
Total Pop. - 2020	35,216	12,462	55,724	17,812	42,681	57,865
Total Pop. - % Change	3.8%	2.0%	2.3%	2.1%	1.4%	3.5%
Median Age	40	43	42	43	41	40
Median Household Income	$36,741	$35,150	$39,410	$39,074	$42,904	$37,618
TennCare Enrollees	8,490	2,907	11,270	3,784	7,166	12,252
TennCare Enrollees As % Of Total Pop.	25.0%	23.8%	20.7%	21.7%	17.0%	21.9%
Persons Below Poverty Level	7,631	2,553	9,786	2,867	6,250	11,457
Persons Below Poverty Level As % Of Total Pop.	22.5%	20.9%	18.0%	16.4%	14.8%	20.5%

	Warren	Van Buren	Monroe	Cumberland	Loudon	Roane	Service Area	State Of Tennessee
Current Year (2016) - Age 65+	40,872	5,651	47,980	17,302	12,971	11,390	272,737	1,012,937
Projected Year (2020 - Age 65+	41,446	5,686	50,062	19,012	14,577	12,315	299,056	1,134,565
Age 65+ - % Change	1.4%	0.6%	4.3%	9.9%	12.4%	8.1%	9.6%	12.0%
Age 65+ - % Total	556.1%	430.4%	461.4%	29.5%	24.9%	21.8%	29.3%	15.2%
Total Pop. - 2016	7,350	1,313	10,398	58,566	51,988	52,300	930,858	6,649,438
Total Pop. - 2020	8,233	1,554	12,384	60,368	52,245	51,602	958,838	6,894,997
Total Pop. - % Change	12.0%	18.4%	19.1%	3.1%	0.5%	-1.3%	3.0%	3.7%
Median Age	39	45	42	50	48	48	42	38
Median Household Income	$34,641	$33,547	$37,595	$39,901	$53,815	$49,949	$45,482	$44,298
TennCare Enrollees	10,217	1,242	10,881	12,934	9,187	11,789	201,899	1,331,838
TennCare Enrollees As % Of Total Pop.	139.0%	94.6%	104.6%	22.1%	17.7%	22.5%	21.7%	20.0%
Persons Below Poverty Level	8,742	1,222	9,126	9,721	7,070	9,414	181,132	1,170,301
Persons Below Poverty Level As % Of Total Pop.	118.9%	93.1%	87.8%	16.6%	13.6%	18.0%	19.5%	17.6%

5.) Section C, Need, Item 6 (Projected Utilization).

The revised table in replacement page 52-R of the application and the table requested in the 1st Supplemental Response are noted.

Please describe what accounts for the 98.5% increase in the utilization of EEH's existing Level II NICU from CY 2015 to CY 2018 (projected Year 1).

Since the Projected Data Chart uses NICU patient days as the unit of measure, please identify NICU patient

days for Children's Hospital @ Erlanger and Erlanger East Hospital in CY 2015 and Year 1 of the project.

Response

The table on the revised page 52-R, has identified the number of cases for the existing Level II unit at *Erlanger East Hospital* in CY 2015 as 270, and the number of cases for CY 2018 as 322. This calculation yields a change of 19.2%, as follows … [((322-270)/270)= 19.2%]. The remainder of the increase, a total of 214 cases for the Level II unit, will be due to the additional six (6) Level II beds which are being added as part of the expansion through CON No. CN0405-047AE. The additional 214 cases are explained by some infants being transferred to the Level II unit from the Level III NICU at *Erlanger East Hospital* as well as the Level IV NICU at *Children's Hospital @ Erlanger* when they are no longer in need of higher acuity NICU care.

As requested, the number of NICU patient days for the neonatal units at both hospitals is shown below.

CY	Childrens @ Erlanger	East Level 2	East Level 3
2015	21,187	2,025	-
2018 *(Year 1)*	21,187	3,850	2,920

6.) Section C, Item 4 (Historical and Projected Data Charts).

The Projected Data Chart showing the financial performance of Erlanger Medical Service's NICU service as a whole in Year 1 and Year 2 of the project is noted. With projected favorable net income of $25,901,693 of the service asa whole in Year 1 (approximately 15.9% of gross operating revenue), what accounts for the significant difference from Erlanger East Hospital's -$530,485 projected loss in Year 1? Please clarify.

Response

The current reimbursement for the Level II unit at *Erlanger East Hospital* is less than the reimbursement for the Level IV NICU at *Children's Hospital @ Erlanger*.

SUPPLEMENTAL #2
January 28, 2016
11:25 am

A F F I D A V I T

STATE OF TENNESSEE |
|
COUNTY OF HAMILTON |

NAME OF FACILITY Erlanger East Hospital

I, Joseph M. Winick, after first being duly sworn, State under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

SIGNATURE

SWORN to and subscribed before me this 27 of January (Month), 2016 (Year), a Notary Public in and for the State of Tennessee, County of Hamilton.

Shelia Hall
NOTARY PUBLIC

My commission expires June 9 (Month / Day), 2018.

SHELIA HALL
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY